PD-ABN-818
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The University of Kansas Medical Center

University of Kansas Cancer Center
Pediatric Oncology Outreach to Hungary

25 March, 1997

Petra Reyes, Project Officer
US Agency for International Development
ENI/HR/HP
Room NS 2669
Washington, D.C. 20523-0053

RE: Grant #EUR 0037-G-00-1078-00
Pediatric Oncology Outreach to Hungary

Dear Ms Reyes,

Enclosed, you will find the Final Program Performance Report for the Pediatric Oncology Outreach to Hungary (POOH) project, a Partnership in Health Care among the University of Kansas Medical Center, Kansas City, Kansas, USA, the Second Department of Pediatrics of the Semmelweis University Medical School, Budapest, Hungary, and the National Institute of Neurosurgery, Budapest, Hungary.

We appreciate the opportunity, provided by USAID to work together in partnership. Through the POOH project, we have created sustainable differences in diagnosis and treatment in pediatric oncology, and have reduced the excess deaths of Hungarian children with cancer in these two hospitals.

Respectfully submitted,

Frederick F. Holmes, M.D.
Principal Investigator.

3901 Rainbow Blvd., Kansas City, Kansas 66160 • (913) 588-4732 • Fax (913) 588-4736

PD-ABN-818
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PEDIATRIC ONCOLOGY OUTREACH TO HUNGARY (POOH)
EUR 0037-g-00-1078-00

PROJECT SPONSORSHIP, FUNDING, AND TIME PERIOD:

The **Pediatric Oncology Outreach to Hungary (POOH)** project is a **"Partnership in Health care"** sponsored by the **US Agency for International Development (USAID)**, and among the **University of Kansas Medical Center (KUMC)**, Kansas City, Kansas, USA, the **Second Department of Pediatrics of the Semmelweis University Medical School (SDP)**, Budapest, Hungary, and the **National Institute of Neurosurgery (NINS)**, Budapest, Hungary.

Total grant funding for the POOH project of **$2,333,473** was awarded in **September, 1991** with a completion date scheduled for **October, 1994.** During the course of the project, the POOH grant was extended three times, without funding, and one time, adding **$350,000** to the grant, bringing the total grant funds to **$2,693,473** over a period of five years and six months, with an end date of **31 March, 1997.**

In addition to USAID funding, the POOH project received a monetary donation from the University of Kansas Medical Center of **$235,191** to be used to help purchaseequipment and materials for SDP and NINS.

DATA ANALYSIS:

The ultimate proof of the success of this venture was to be improvement in survival for pediatric cancer patients in Hungary as compared to the world standard. Using the actuarial survival program which is a part of the POOH Pediatric Tumor Registry, survival for, 1.) All coded tumors, 2.) All leukemias, 3.) All central nervous system tumors was computed for NINS and SDP and compared with KUMC. The intervals of 10, 30, and 60 months were chosen arbitrarily to represent the entire course of this grant.

The table below, shows 10 month survival to be comparable in Hungary and Kansas. At 30 months Hungary is shown to be catching up, and at 60 months the gap is still wide. Considering that this project was for 60 months, this is a striking improvement.

Pediatric Cancer Survival, 1 Month Intervals
Age at diagnosis =0-18 years
Date of diagnosis = 1991-1995

ALL CODED TUMORS

SURVIVAL TIME	10 MONTHS	30 MONTHS	60 MONTHS
Survival Percentage KUMC	92.3	81.9	71.3
Survival Percentage POOH	95.0	80.0	48.0

ALL LEUKEMIAS

SURVIVAL TIME	10 MONTHS	30 MONTHS	60 MONTHS
Survival Percentage KUMC	90.5	77.7	72.5
Survival Percentage POOH	90.0	60.0	*----

*Could not be determined

ALL CENTRAL NERVOUS SYSTEM TUMORS

SURVIVAL TIME	10 MONTHS	30 MONTHS	60 MONTHS
Survival Percentage KUMC	84.7	72.0	47.4
Survival Percentage POOH	90.0	70.0	*---

*Could not be determined

PROGRAMMATIC AND MANAGERIAL LEADERSHIP STRUCTURE:

The POOH project's programmatic and managerial leadership was clearly defined from its inception and remained intact throughout the duration of the grant. **(Organizational chart appended as A.)** This clearly defined structure provided a firm foundation for the project and facilitated open communication among the partnership participants throughout the course of the project.

US Component Structure

Principal Investigator (PI), KUMC: Frederick F. Holmes, M.D., Professor of Medicine, acted as Principal Investigator throughout the full course of the project. Dr. Holmes oversaw every aspect of the program working closely with the Senior Program Coordinator, as well as with all other project principals.

Co-Investigators (CO-INV), KUMC: John J. Kepes, M.D., Professor of Pathology and Tribhawan S. Vats, M.D., Professor of Pediatrics and Director of the Department of Pediatric Hematology/Oncology, acted as KUMC's co-investigators for the project. Dr. John Kepes, a native Hungarian, provided valuable managerial assistance through his ability to speak and write Hungarian fluently, as well as through his appreciation for the workings of the Hungarian medical community. Before Dr. Kepes left Hungary in 1957, he was the Pathologist-in-Chief at the National Institute of Neurosurgery, thus providing an important link to the neurosurgical component of the project. Dr. Tribhawan Vats, Director of the Department of Pediatric Hematology/Oncology provided guidance in those aspects of the project involving the training of nurses, physicians, and scientists, and in upgrading treatment protocols.

Senior Program Coordinator (SPC), KUMC: Ms Ariel B. Baker filled the position of Senior Program Coordinator for the full grant period. Ms Baker was directly responsible to the project's Principal Investigator and indirectly responsible to all US and Hungarian co-investigators. Ms Baker worked directly with each Hungarian coordinator for the two Hungarian partner hospitals. Although the Senior Program Coordinator oversaw the work of the project's Hungarian coordinators in terms of task delegation, she maintained a team-like approach fostering open communication and professional comradeship. Ms Baker communicated almost daily with each of the Hungarian coordinators through telephone, FAX, post, and e-mail.

Hungarian Component Structure

Co-Investigator (CO-INV), SDP: Prof. Dezső Schuler, Director of the Pediatric Oncology Institute at SDP, acted as co-investigator to the project throughout its full term. Prof. Schuler oversaw all aspects of the project relating to SDP, which included training project nurses, physicians, and scientists, protocol upgrade, and selection of equipment to be purchased for SDP. Prof. Schuler worked closely with Dr. Frederick Holmes as well as with the SDP Program Coordinator and the Senior Program Coordinator.

Associate Co-Investigators (ACI), SDP: Two Associate Co-Investigators participated in the POOH project at SDP. Dr. Joseph Borsi, Chief of Oncology , and Dr. Hedvig Bodánszky, Pediatric Gastroenterologist assisted Prof. Schuler wherever necessary and acted as his deputies when called upon. They remained cognizant of all aspects of the POOH project and participated in program planning activities.

Program Coordinator PC), SDP: Mrs. Marianna Thomka, held the position of SDP Program Coordinator for the full term of the project. Mrs. Thomka was directly responsible to Prof. Schuler and indirectly to Dr. Holmes. She worked in close communication with Ariel Baker, as well as with the NINS program coordinator, collaborating with them in all aspects of the project at SDP.

Co-Investigator (CO-INV), NINS: Prof. Emil Pásztor, Director of the National Institute of Neurosurgery acted as co-investigator to the POOH project until 1993 when he retired as Director of NINS. From the beginning of the project until his retirement, Prof. Pásztor oversaw all aspects of the program at NINS. Upon his retirement, Prof. István Nyáry took over Directorship of NINS and with it, the position and duties of Co-Investigator of the POOH project at NINS. Prof. Nyáry was well informed of the activities of the POOH project, having assisted Prof. Pásztor as his second-in-command at NINS and as an associate co-investigator for the POOH project. Prof. Pásztor remained interested and available to consult for the project until its completion in 1997.

Associate Co-Investigators (ACI), SDP: Two associate co-investigators participated in the POOH project at NINS. From the beginning of the project in 1991 until Prof. Emil Pásztor's retirement as Director of NINS in 1993, Prof. István Nyáry, Chief of Neurosurgery assisted Prof. Pásztor in all aspects of the project and acted as his deputy when needed. Prof. Dénes Áfra, Neurosurgeon, was associate co-investigator for the full course of the project. He assisted Prof. Pásztor, and then Prof. Nyáry, after Prof. Pásztor's retirement, in all aspects of the POOH project.

Program Coordinator (PC), NINS: Over the course of the POOH project, NINS, employed three program coordinators. Mr. András Kaliszky filled the position from the program's beginning until December, 1993, when he left to pursue a Masters degree in Business Administration at the University of Wisconsin. Mr. Adrian Hart followed Mr. Kaliszky from January, 1994 through September, 1995. Mr. Hart left the position to return, with his Hungarian wife, to his native England. Ms Ágnes Mondok then took over the responsibilities of program coordinator at NINS until the end of the project. All three coordinators were directly responsible, first to Prof. Pásztor, and then to Prof. Nyáry, and were indirectly responsible to Dr. Holmes. They all worked closely with Ariel Baker and Marianna Thomka, collaborating with them in all aspects of the project at NINS.

PAYMENT OF SALARIES IN HUNGARY:

In order to accomplish the goals of the POOH project it was necessary to pay salaries to some select personnel at each of the Hungarian hospitals. A bank account was set up at the General Bank and Trust Co. Ltd. in Budapest for each Hungarian hospital. Funds could then be transferred directly from KUMC to their accounts. A contract to encumber budgeted funds, according to rules set out by the State of Kansas, Unviersity of Kansas, was drawn up for each Hungarian Hospital. Initial start-up money, to begin the project, was transferred to the accounts for each Hungarian hospital at the beginning of the grant by KUMC. Thereafter, an accounting of expenditures was made to KUMC by SDP and NINS at each quarter end, and then reimbursed to SDP and NINS by KUMC. Financial audits were conducted periodically and submitted to KUMC. A final audit of transferred funds was performed at each hospital at project's end.

Although, their job funding was paid through the POOH project, the Hungarian doctors and nurses who worked on the POOH project were officially employees of either NINS or SDP and were subject only to Hungarian taxation and laws. The employees were selected by Prof. Dezső Schuler at SDP and Prof. Emil Pásztor at NINS. The salaries that the Hungarian employees were paid were determined by Hungarian hospital regulations and procedures at SDP and NINS.

PROJECT OBJECTIVES AND PROGRAM DESCRIPTION:

The main objective of the POOH project was to put into place sustainable procedures and to create changes that would markedly reduce the excess deaths in Hungarian children with cancer. During the first three years of the project, objectives were identified and goals were established. During the final two years of the POOH project, it was decided that, in addition to maintaining the current programs, knowledge gained during the first three years should be disseminated to

as many Hungarian and East European physicians and hospitals as possible.

Following, is a description of project objectives and how they were met:

CREATE A STATISTICAL UNIT FOR REGISTRATION OF DIAGNOSIS, TREATMENT, AND SURVIVAL WHICH WILL ORGANIZE AND IMPROVE LONG-TERM PATIENT FOLLOW-UP:

The specific aim of this objective was to create the means whereby SDP and NINS could better follow their patients and monitor their course of treatment. With such systematic analysis, outcomes of treatment could be evaluated, individually or collectively. An infrastructure would then be in place that would allow patients to be followed from diagnosis onward. An aggressive short and long-term follow-up was necessary to anticipate and overcome the complications that occur during and after treatment. Unless the problems and efficacy of a protocol become known, its full benefit cannot be determined.

The statistical unit devised and put into place by the POOH project to accomplish this goal was an institution-based pediatric tumor registry. This menu-driven registry is simple enough in design to allow its use in any country worldwide. The registry program requires an IBM compatible computer with operating system DOS 5.0 or higher and one MEG of central memory.

The POOH Pediatric Tumor Registry maintains two types of user files in its data base. They are: 1.) **DATA Files** containing clinical information related to patients, and 2.) **Reference Files** containing stable information such as diagnosis dictionaries and institutional data.

Clinical information in the Data Files is divided in five parts. The first part, Patient Master File (PTMAST) contains demographic information pertaining to a single patient and requires a unique identification number for each patient. Secondly, Patient/Diagnosis file (DXPT) contains one record for each tumor diagnosis on each patient. This file links the diagnosis with the patient. Both the morphological code and topographic code are included, as well as date of diagnosis. The third part of the Data Files, Patient Follow-up File (FUP) contains follow-up data linked to the patient's diagnosis record. Fourth, the Disease Specific File (DISPEC) contains records with a standard data format and must be linked to an existing record in the Patient/Diagnosis File. The fifth part of the Data files is the Joint Commission Evaluation File (JCE) containing information which can be used to assist in quality assurance measures.

The Reference Files are divided into seven sections. A Tumor Morphology Dictionary (TMDICT) contains a list of tumor morphology diagnoses along with

topographic locations. A Tumor Topographic Dictionary (TPDICT) contains topographic codes from the International Classification of Diseases for Oncology (ICDO). Reporting Institution File (REPINS) contains a record for each reporting institution, should more than one institution submit data to the same registry. A Tumor Topography Dictionary (TPDICT) contains the list of ICDO topography codes for the given morphology code. The Reporting Institution File (REPINS) contains demographic information and contact person for each institution entering data into the registry. Four final sections, the Outline File (OUTLINE), the Labels File (LBLS), the General Terms File (GENTERMS), and Specific Terms File (SPECTRM) are for programmer use.

The POOH Pediatric Tumor Registry contains statistical survival analysis capabilities as well, providing survival function estimates, survival mean and quantile estimates, with step graph of survival curve function.

The Pediatric Oncology Outreach to Hungary project is entering data on all patients diagnosed with leukemia and malignant solid tumors who have been treated and followed since 1987. The new number of patients diagnosed with malignancies at SDP and NINS, fluctuate between 43-76 cases per year. Follow-up information is entered at least annually. Childhood leukemia and cancer frequencies and age distributions are generated annually. Survival rates can be compared from 1987 to present, helping to evaluate current treatment protocols. **(POOH Pediatric Tumor Registry on diskette, is appended as B.) (POOH Pediatric Tumor Registry Program Manual is appended as C.)**

TRAIN A CADRE OF PEDIATRIC ONCOLOGY NURSE-CLINICIANS:

Pediatric Oncology Nurse Clinicians are essential in the United States for implementation of the continuous, intensive care that is required to bring children with cancer through the most rigorous phases of their treatment. The POOH project set a high priority on creating a program to integrate Hungarian pediatric nurses into a multi disciplinary treatment team and on creating the new role of Pediatric Oncology Nurse Clinician at SDP and NINS.

Nurses' Training at KUMC

During the first three years of the POOH project, six pediatric nurses from each of the Hungarian partner hospitals, totaling twelve nurses all together, came to KUMC to study with the Pediatric Oncology Nurse Clinicians there and with Dr. Tribhawan Vats, Director of Pediatric Hematology/Oncology at KUMC. Ten of the Hungarian nurses came for three-month periods each. Two of the Hungarian nurses traveled to KUMC for two, three-month training sessions each, for a total of six months of training. **(List of nurses' names according to year of attendance and hospital affiliation appended as D.)**

Each Hungarian nurse held some competency in English language before she traveled to KUMC. In addition, the US Peace Corps in Budapest provided English language classes for the nurses before, and after, they traveled to KUMC. Dr. John Kepes, provided help with language translation when necessary.

A Nursing Syllabus was created by the Pediatric Oncology Nurse Clinicians at KUMC and was translated into Hungarian by Dr. Kepes. **(English/Hungarian Nursing Syllabus appended as Ea,b.)** The nurses also recorded lectures and lessons, listening to the information again later and bringing questions back to the KUMC nurse clinicians and Dr. Vats the next day.

The Hungarian nurses accompanied the KUMC Pediatric Nurse Clinicians on their daily clinical rounds. The role of the nurse clinician as parent/patient liaison and educator was introduced to them, and they observed, first-hand, the multi disciplinary team approach to treatment.

Nurses' Training Workshops Held in Budapest 1994 - 1996

Four Nurses' Training Workshops were conducted in Budapest from 1994 - 1996, with a total of sixty-one nurses attending from every hospital in Hungary with a pediatric component.**(Map of hospitals participating in workshops, appended as F.)**

The goal of the workshops was to share information gained by the Hungarian nurses who had been trained at KUMC, with nurses at other hospitals in Hungary. During the training workshops, didactic lectures were conducted by Hungarian faculty, KUMC-trained Hungarian nurses, Dr. Tribhawan Vats, and by KUMC Pediatric Oncology Nurse Clinicians.

As a result of the training efforts of the POOH project, quality assurance and standards in pediatric oncology nursing were established, the Association of Hungarian Pediatric Oncology Nurses was founded, a nation-wide registration of all nurses in Hungary was begun in June, 1996, and a program to train advanced level nurses as practitioners in the area of pediatric oncology was also begun in 1996.

An on-going professional relationship was established among the Pediatric Oncology Nurse Clinicians at KUMC and the Pediatric Nurses in Hungary. Ms Lavonne Ridder, Pediatric Oncology Nurse Clinician at KUMC devoted a great deal of time to the POOH project's nursing component, and as a result, was made an honorary member of the Association of Hungarian Pediatric Oncology Nurses. She will continue her dialogue with that association and its members long after the end

of USIAD funding for the POOH project. **(Nursing workshop program reports appended as G.)**

ESTABLISH A MULTI DISCIPLINARY APPROACH AS THE NORM FOR CARE OF CHILDREN WITH CANCER:

Training Hungarian physicians and scientists at KUMC

It was a goal of the POOH project to pursue treatment of childhood neoplasms on a multi disciplinary basis. The input of a diverse spectrum of subspecialists is needed to bring every possible medical advantage to bear on the treatment of these diseases. The multi disciplinary approach has been one of the key innovations responsible for the lowering of mortality rates in childhood cancer patients in the US.

Ten physicians from various disciplines and one pharmacologist traveled from Hungary to KUMC for training periods of one month each. During that time, they saw directly, the benefits of the multi disciplinary team approach to treatment. This included witnessing the advantages to treatment and follow-up through the inclusions of the Pediatric Oncology Nurse Clinician.

Returning to their old roles with newly defined perspectives of the importance of working as a team, has created a sustainable difference in their approach to treatment. **(List of physicians and the scientist trained at KUMC, their disciplines and areas of interest, by year of training is appended as H.)**

Medical Symposia and Continuing Education

In addition to the training sessions at KUMC, additional education and training was provided through medical symposia and continuing education apart from the POOH project. The POOH project sent five Hungarian physicians, one pharmacologist, and two nurses to medical symposia and training. **(List of medical symposia and continuing educational training appended as I.)** This exposure to the medical community outside Hungary, has fostered new professional relationships for the Hungarian participants and has broadened their outlook toward treatment of pediatric cancer. In some cases, the Hungarian participants presented lectures or posters as well, furthering their experience in the international medical community.

IMPLEMENT CONTEMPORARY DIAGNOSTIC AND TREATMENT PROTOCOLS:

Lack of contemporary diagnostic and treatment protocols is one of the root causes of excess mortality in Hungarian children with cancer. Dr. Tribhawan Vats, KUMC

monitored the introduction of current treatment protocols for brain tumors and Hodgkin's Disease into the treatment plans at SDP and NINS. These protocols are in current use with clinical trial groups (POG and SWOG) and have been approved for human subjects. **(Protocols appended as Ja,b.)**

PROVIDE EQUIPMENT AND MATERIALS NEEDED TO UPGRADE TREATMENT CAPABILITIES AT SDP AND NINS:

Over $400,000 in equipment and materials were purchased with USAID funds for the Hungarian partner hospitals through the POOH project. In addition to USAID funds, a donation of $235,191 from KUMC to the POOH project was used to purchase equipment for each of the Hungarian hospitals. Finally, through the efforts of Dr. Frederick Holmes, PI, KUMC, a US non-profit organization entitled Direct Relief International (DRI) undertook to donate medical equipment and supplies to SDP and NINS, as well as, to the First Department of Pediatrics of the Semmelweis University Medical School (FDP). DRI has indicated that it will continue its donations to SDP, NINS, and FDP on an on-going basis, after the POOH project funding has ended. To date, DRI has donated over $43,000 in medical equipment and supplies to the three hospitals. Prof. Dezső Schuler, SDP, is the Hungarian contact and consignee for all donations from DRI. **(List of equipment and materials, purchased and donated appended as K.)**

IMPROVE ACCESS TO THE MEDICAL LITERATURE:

Medical knowledge needed to force mortality rates in Pediatric Oncology down, advances rapidly. The means of remaining current is partly dependent upon access to up-to-date medical literature.

In order to assure that the Hungarian health professionals at SDP and NINS had the same access to current medical literature that is available in the US, the POOH project purchased ninety-seven medical text books for SDP and NINS along with eight medical journal subscriptions, which included Current Contents for Life Sciences and Clinical Medicine on CDROM. In addition, donations of back issues for twenty medical journal subscriptions were donated to SDP and NINS on an on-going basis by physicians at KUMC. One current journal subscription was donated as well. **(List of medical journal subscriptions and textbooks, along with journals donated, appended as L.)**

DISSEMINATION OF INFORMATION THROUGH MEDICAL SYMPOSIA:

Dissemination of valuable information has been one of the foremost objectives of the POOH project. To facilitate the accomplishment of that goal, the POOH project has conducted an annual medical symposium each year beginning in 1992. With each meeting, an effort was made to reach a broader audience. The culmination of this effort was the POOH project's final symposium held in 1996 and sponsored by the New York Academy of Sciences.

The First Annual Winnie-the-POOH Symposium on Childhood Malignancies was held in Budapest, Hungary in August, 1992. Approximately ninety physicians and scientists attended the conference. The focus of the symposium was Pediatric Central Nervous System tumors.

The 1993, Second Annual Winnie-the-POOH Symposium on Pediatric Malignancies was held in Kansas City, Missouri, USA. Thirty Hungarian health care professionals from SDP and NINS were hosted by the POOH project at the meeting. It is note worthy, that for the first time, nursing in Hungary was presented as an official topic at such an international conference. A lecture was presented by two of the KUMC-trained Hungarian nurses. Approximately one hundred physicians and nurses attended the conference.

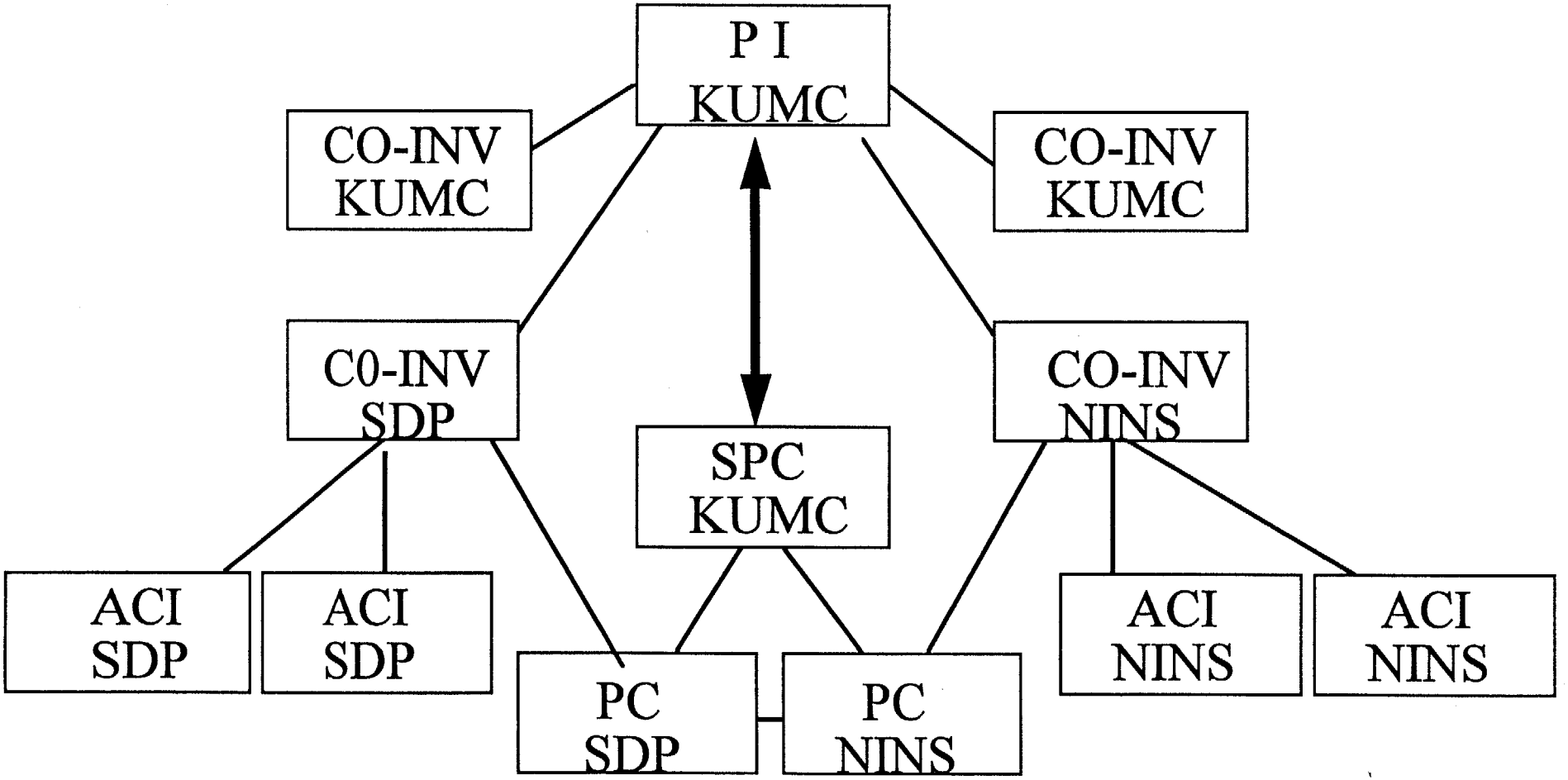
The Third Annual Winnie-the-POOH Symposium on Pediatric Malignancies was held in Lillafüred, Hungary in 1994. The meeting was integrated with the Hungarian National Oncology Conference, which provided a wider diversity among physicians attending the lectures. As in 1993, Pediatric Oncology nurses attended the conference as well, which was an innovation in Hungary. Approximately one hundred fifty attended the meeting.

In 1995, the Fourth Annual Winnie-the-POOH Symposium on Pediatric Malignancies was held in Kecskemét, Hungary. It was integrated with the International Congress of the Hungarian Society for Pediatric Neurology, Neurosurgery, Child and Adolescent Psychiatry. Approximately two hundred fifty physicians attended the conference. The POOH project hosted ten physicians from countries surrounding Hungary to the symposium, with eight of those physicians presenting lectures there.

The final medical symposium of the POOH project was held in Budapest, Hungary in October, 1996. Under the sponsorship of the New York Academy of Sciences, the conference was titled, "Challenges and Opportunities in Pediatric Oncology". His excellency, Árpád Göncz, President of Hungary, was present to begin the conference, as was the Honorable Donald M. Blinken, US Ambassador to Hungary. Sixty physicians and scientists from countries surrounding Hungary and from

satellite hospitals within Hungary were hosted as quests of the POOH project. Twenty-three category I, continuing medical education credits of the Physician's Recognition Award of the American Medical Association were offered through the conference. The proceedings of the meeting will be published in the Annals of the New York Academy of Sciences. A volume of the NYAS Annals will be given to each participant and invited guest as a means of disseminating the valuable information put forth through the symposium. Approximately two hundred physicians and scientists attended the conference.
(Agendas for each annual conference are appended as Ma-e.)

PROGRAMMATIC AND MANAGERIAL LEADERSHIP STRUCTURE



USER'S GUIDE
(For use with the POOH Tumor 6.10 Registry Program)

Progammed by: Robert E. Bolinger, M.D., University of Kansas Medical Center
Beta Testing by: Cathy D. Boysen, University of Kansas Medical Center

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USER'S GUIDE TO THE POOH DATABASE
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OVERVIEW
The use of this Data Base requires an IBM type of computer with operating system DOS 5.0 or higher and one MEG of Central Memory. The monitor should be VGA and the printer should have the capability for printer panel programming of fonts. If foreign font is to used, this should be loaded into extended memory with the appropriate HIMEM command.

KEYBOARD CONVENTIONS: This version of the program is directed from the keyboard. The arrow keys are functional for cursor control. Screen forms for fill in information are frequently encountered. When all of the data on such a screen is filled in, or at least as much as you need, the screen can be saved by pressing CTRL_ENTER. Thus a screen need not be completely filled in or not filled in at all. To leave a screen without saving anything press CTRL_ESC. To abort a program without saving, press CTRL_BREAK. This will return you to DOS.

Data input personnel need only the program TUMOR.EXE. One station in an area should also have access to:

1. The program TRSTAT.EXE (by Mr. Ed Brown) for development of the survival statistics
2. The CLARION development package version 2.0 to be used for direct editing of data files and recovery of corrupted data files. Only a programmer should use this package.

INTRODUCTION: There are two types of user files in the data base:
1) Data Files containing clinical information related to patients and
2) Reference files containing stable information such as diagnosis dictionaries and institutional data.

The Data Files are:

1) Patient Master File (PTMAST) which contains demographic information pertaining to a single patient. The program requires a unique identification number (IDNO) not to exceed 15 characters for each patient. The first three characters of this number should be made from the reporting institution code. This is the "root institution" and refers to the first institution registering the patient and should remain constant throughout the course of the illness, even though subsequent reporting may be based in other institutions.
The other twelve digits of the ID number may be from the institution's internal coding for patients (e.g. hospital number).

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2) Patient/Diagnosis File (DXPT) contains one record for each tumor diagnosis on each patient. This file links the diagnosis with the particular patient.Both the morphologic and the topographic diagnoses are included as well as the date of the diagnosis. Also there is a pointer back to the disease category record in the file = GENTERMS. Thus, the GENTERMS file should not be sorted or rearranged.

   The official date of this diagnosis becomes the key by which the Follow-up, Joint Commission, and Disease Specific records are linked back onto the patient diagnosis root. Thus the patient diagnosis record file (DXPT) can be sorted without losing the links.

3) Patient Follow Up File (FUP). This contains follow-up data on a given patient. The follow-up record must be linked to the particular patient diagnosis record. A record contains a pointer back to that patient diagnosis record. More than one follow-up record per diagnosis keyed on the date of creation of the record is possible providing the dates of different diagnoses are not the same day.

(IT IS RECOMMENDED THAT THE FOLLOWING DISEASE SPECIFIC FILE NOT BE USED IN THIS VERSION WITHOUT ADVICE FROM KUMC. SKIP TO PARAGRAPH 5))

4) Disease Specific File (DISPEC). This contains records with a standard data format but with a variable set of labels for each disease type. Each record in this file must be linked to an existing record in the Patient/Diagnosis File. The details of using this file are discussed below in Paragraph 1.5. This capability should not be used without consulting the program manager since the steps for creation and use are somewhat complicated. Thus the general user need not be concerned with the contents of paragraph 1.5.

5) Joint Commission Evaluation File (JCE) - This file contains information for Joint Commission Evaluation. Each JCE record is linked to a specific root patient diagnosis record in the same manner that the follow-up record is linked. It is likely that there would be only one JCE record per diagnosis.

The Reference Files are:

1) Tumor Morphology Dictionary (TMDICT) contains a list of tumor morphology diagnoses along with the possible topographic locations. The topography locations that can be associated with a given morphology diagnosis may be:
   a) a sequential list of codes from the ICD-O catalog in which case the start and stop topography codes for this list are carried in the fields TPSTART and TPSTOP.

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b) a random list of topography codes, in which case the random list is carried in the general terms file (GENTERMS) referenced by a unique collating name for that particular set. The morphologic dictionary record will contain this unique name in the field called INTLST.

2) Tumor Topography Dictionary (TPDICT) contains the list of ICD Topography codes for the given morphology code.

3) Reporting Institution File (REPINS) contains a record for each reporting institution. The record contains the demographic information of each institution indicating address and person to contact at each location. The data manager must assign a unique three digit code to each institution. These three digits are used as the first three digits of the unique patient identification number.

4) Outline File (OUTLINE) contains records used by the program for screen displays and filters. This file is used only by the programmer.

5) Labels File (LBLS) contains labels for output displays. It is used only by the programmer.

6) General Terms File (GENTERMS) contains lists of terms other than diagnostic to be used by the program. Only the programmer should alter this file. The list of Disease Categories and the lists of Major Fields for the Disease Specific (DISPEC) records are found here.

7) Specific Terms File (SPECTRM) contains lists of the labels and descriptors for the Sub-Fields under the Major Fields in the formatted option for processing the Disease Specific (DISPEC) records. This file should not be sorted.

PROCEDURES: The procedures may be divided into three groups:

1) USER INPUT PROCEDURES for entering patient specific information---
Each of these procedures must be preceded by the registration of a new patient or the retrieval of an established patient record. When a patient is identified the name and ID Number appear on the lower left hand part of the screen and the proper patient master record (PTMAST) becomes current in memory.

2) HOUSEKEEPING PROCEDURES, executed usually by a data manager---
These procedures are used to edit the dictionaries, the reporting institution files, and any of the above data files where corrections, additions and deletions need to be made. It is strongly

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recommended that new records be added only by the "user input" procedures (paragraph above) and not under these "housekeeping" procedures. This is because links need to be set up for new records. Editing of existing records can be carried out under this option provided that linkage fields are not changed.

ENTERING THE PROGRAM: The program is entered from the appropriate computer directory by typing in from DOS the command TUMOR. The program will load for about 10 seconds and the logo will appear. The first menu will appear when the ENTER key is pressed. Items can be selected from a menu by using the cursor control keys. When an input screen is completed, the program can be resumed at any point by pressing CTRL-ENTER. Each step or each screen can be cancelled by striking ESCape or CTRL-ESC which returns the program to the previous screen.

Scrolling screens are used frequently in the program. These screens may contain a selected list of items from which to choose. The selected item can be highlighted by moving the cursor keys (Page-up,Page-down, Arrow up, Arrow down) to the selected item and then to select the item, striking Enter. The scrolling list may be longer than the monitor screen but the cursor keys permit the system to automatically move to items not appearing on the current screen. In some cases more than one selection is permitted. IT IS IMPORTANT TO REMEMBER that if no selection is made the user should srike ESCape. Screens where multiple selections are permitted can be recognized by the fact that when the item has been selected the screen remains in view.If only one selection is permitted from the screen, then the screen will change as soon as the selection is made and the ENTER button pressed. In the multiple selection screens, a selection is made by pressing ENTER etc until all selections are made after which the ESCape button should be pressed.

Some of the screens will use special function keys:

- F1 = A Help Screen for that screen can be displayed When finished strike ESCape
- F5 = A brief summary of current diagnoses and follow-records for the current patient will be displayed on a scrolling screen for viewing only.
- F7 = When a text screen is completed the F7 key should be pressed; NOT the ENTER key.

MAIN MENU - "Data Base Options"

This appears when the program begins and can be returned to by pressing ESCAPE's from other parts of the program.

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POOH Database

(Screen 1)

Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT Patient Related Data Input Select Printed Reports Erase Patient Files REQUIRES NO IDENTIFICATION OF PATIENT Data File Editing Procedures Reference File Editing Procedures Create Disease Specific Sub-Fields Rectify Temporary Diagnosis Codes Process Survival Curves
Make Selection or ESC to Return;F1 for Help

The options selected on this screen are described below in order of their listing on the screen.

1.0 "Options For Patient Data Input" - Patient data input requires first that a patient be identified, either as a new registration or an established patient. When identified the ID number and name of the patient appear in the lower left hand side of the screen. Changing to another patient requires returning to this screen and repeating the selection process.
The menu for selection of steps in the input of patient data are as follows:

(Screen 2)

Options for Patient Data Input
Identify Current Patient Edit/View/Enter Tumor Diagnosis Edit/View/Enter Follow-up Data Edit/View/Enter Joint Commission Data Edit/View/Enter Disease Specific Data
Make Selection or ESC; F1 for Help

1.1 "Identify Current Patient" - The steps for this begin with the options to register a new patient or select an established patient.

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(Screen 27)

```
IDENTIFY CURRENT PATIENT
 1 = NEW PATIENT  INPUT

 2 = ESTABLISHED PATIENT
            -
 0 = ABORT STEP
```

1.11 "New Patient Input" - The Identification number for a new patient is assigned from the user's patient numbering system. It should be remembered that the first three digits in the ID number must be those identifying the reporting institution.

A screen will appear requesting input of the new patient identification number using the institutional code as the first three digits.

(Screen 30)

```
ENTER NEW PATIENT
    ID NUMBER
FIRST THREE DIGITS
MUST BE REPORTING
 INSTITUTION CODE
---------------
```

A scrolling screen showing the list of reporting institutions with their code number appears and the user should select the institution from which this new patient is being registered.
A screen displaying the current institution code appears for reference purposes.

(Screen 66)

```
REPORTING
INSTITUTION CODE
      IS
     ---
      -
```

If no institution code is selected from the scrolling list, the input screen for describing a new institution will appear and should be filled in or ESCaped from.

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(Screen 18)

```
          Reference Records for Reporting Institutions
          ---------------------------------------------
Institutional ID Code  INSTID :---
Name of Institution    INAME  :--------------------------------
Street Address         ISTREET:-------------------------
City                   ICITY  :-------------------------
Postal Code            IZIP   :----------
Country                INATION:---
Person of Contact      CONTACT:--------------------------------
```

After the new patient ID number has been established the Patient Master input form appears for input

(Screen 3)

```
 Data Input Form for Master    FIRST THREE DIGITS OF PATIENT ID NO
                               MUST BE ROOT INSTITUTION CODE NUMBER
Patient ID Number        PTID   :----------              RACE CODES
Patient Last Name        PLNAME :----------------           --
Patient First Name       PFNAME :------------               |
Patient Middle Name      PMNAME :------------               |
Mother Last Name (Maiden)MLNAME :----------------
Mother First Name        MFNAME :------------
Mother Middle Name       MMNAME :------------
Date of Birth            DOB    :yyyymmdd
Date of First Diagnosis  DOE    :yyyymmdd
Race/Ethnicity Code      RACE   :--
Sex (m=1;2=F;3=Other)    SEX    :-
Street Address           STREET :-------------------------
City Address             CITY   :-------------------------
State of Residence       STATE  :---
Postal Code              ZIP    :----------  PRESS F1 FOR HELP
Country Code             NATION :---         PRESS F5 FOR SUMMARY
Father's Name:Last:----------------First:------------:Mid Initial -
Place of Birth-- City:-------------------------State:--- Nation:---
Postal Code of Birth     BZIP   :----------
```

Required fields for creating a record of this type are

1. Patient identification number - The first three digits of this number must be the unique code assigned to the reporting institution. The remaining 12 digits may be whatever coding system the reporting institution uses to identity patients in their system.

2. Patient name fields.

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3. Date of First Diagnosis. This is considered to be the registration date.

Other data may be entered at a later date.

1.12 "Established Patient Input" - There are three options for finding an established patient. The most efficient way is to know the ID number of the patient but if this is not known, there are two other options for finding it:

(Screen 28)

```
SELECT SOURCE FOR ID NUMBER
  FOR ESTABLISHED PATIENT

1 = ENTER NUMBER FROM KEYBOARD

2 = SEARCH FOR NUMBER BY LAST NAME

3 = SEARCH ENTIRE MASTER LIST

9 = CANCEL REQUEST
                -
```

Option 1: Enter ID number from the keyboard

(Screen 29)

```
ENTER ID NUMBER
FOR ESTABLISHED
    PATIENT

---------------
```

Option 2: Enter last name for which to search

(Screen 31)

```
ENTER LAST NAME FOR WHICH TO SEARCH
----------------
```

A scrolling screen will appear showing patients with the requested last name. If the name is found it can be selected and becomes the current patient name. If the name is not in the scrolling list, strike ESCape and return to the menu.

Option 3: To search the entire master list a scrolling screen will appear and a selection can be made. If the patient is not in the list, strike ESCape and the program will return to NEW PATIENT INPUT.

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1.2 "Edit/View/Enter Tumor Diagnosis--This may be the creation of a new Patient/Diagnosis record or the updating of an existing record or simply viewing the record.

Each tumor diagnosis belongs to one of the following of disease. The category must be declared from a scrolling screen before a diagnosis is selected in order to enter a new diagnosis. Categories are as follows:

10 Leukemias
12 Non-Hodgkin's Lymphoma
14 Hodgkin's Disease
16 Wilm's tumor
18 Neuroblastoma
20 Osteogenic Sarcoma
22 Ewing's sarcoma
24 Rhabdomyosarcoma
26 Central Nervous System
28 Other rare tumors
30 Retinoblastoma

The tumor diagnosis consists of two parts: A Morphologic diagnosis and a Topographic diagnosis. Each are coded by the ICD O lists. The Patient/Diagnosis File (DXPT) links the patient ID number with a diagnosis. There is one record for each diagnosis on a given patient. This record must exist before a disease specific record, a follow-up, or a JCE record can be created. The pointer is to the disease category record in GENTERMS.
(The field POINTER should not be changed by the user)
Any new record of this type should be added from this program menu.
The official date of this diagnosis (DTDX) is used as a pointer for linking other records to this diagnosis.

The general scheme for entering a tumor diagnosis is shown below. In each case there is the option to select the diagnosis from the dictionary, either Morphology or Topography dictionary or to enter it from the Keyboard if not found in the current dictionary. If new diagnoses are to be added to the dictionaries it is STRONGLY RECOMMENDED that they be added in advance of entering a patient diagnosis, under the option below for updating Reference Files. (Paragraph 5.8)

However, if new diagnoses are entered from the keyboard the program will assign a temporary "ICD" code beginning with "T" or "M" and enter this into the dictionary. It is the responsibility of the Data Manager to rectify these temporary codes to standard ICD codes as soon as possible (Paragraph 7.0 below)

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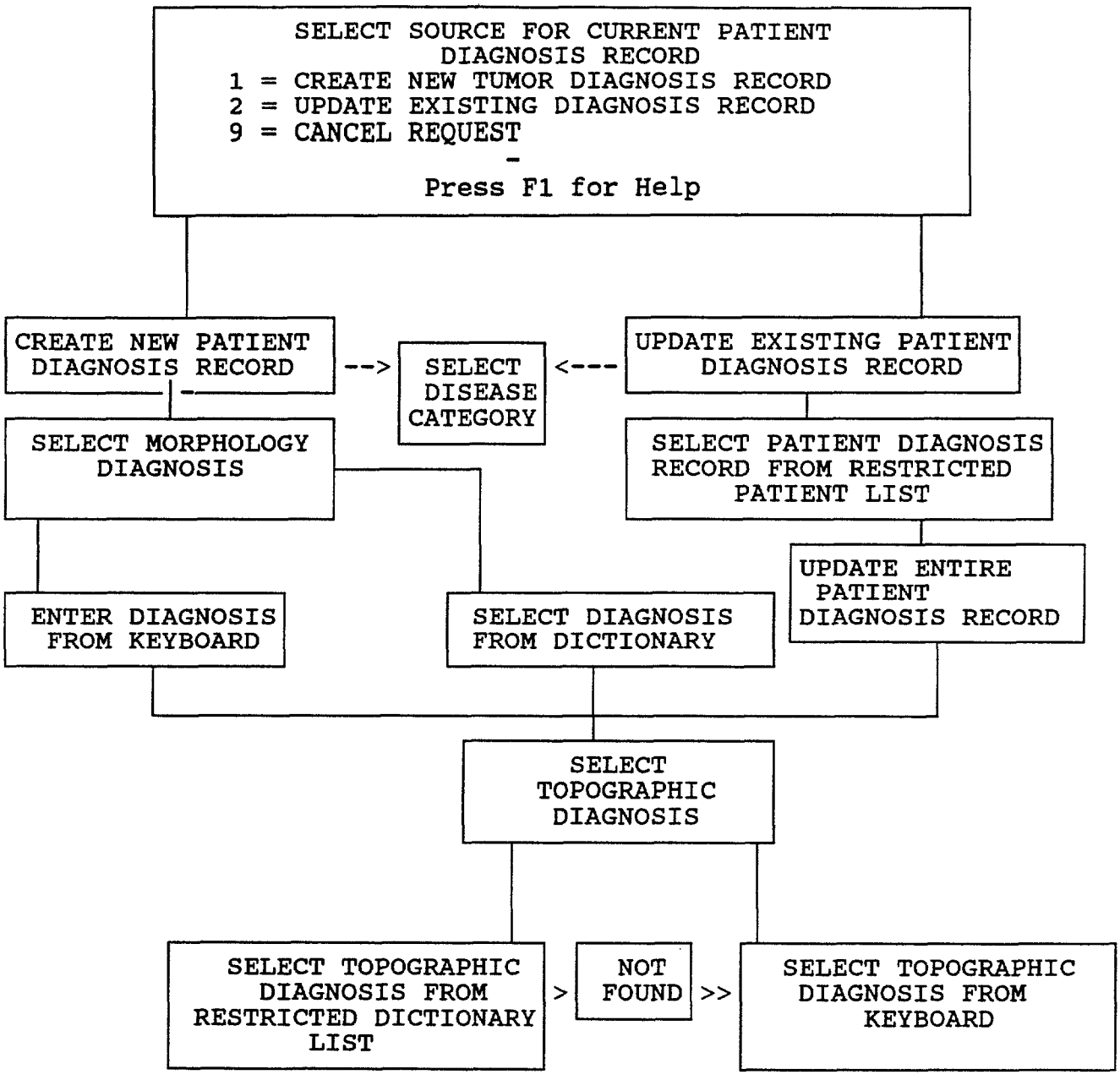
(Screen 34)

TUMOR DIAGNOSIS SCHEME



1.21 "Create New Tumor Diagnosis Record"

The format of the Patient Diagnosis Record is shown below.

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(Screen 4)

```
                        Update Patient Diagnosis
                      ----------------------------
PATIENT ID NUMBER            PTID   :----------
MORPHOLOGY ICD   CODE        MDXID  :------
MORPHOLOGY DIAGNOSIS         MDXLIT :--------------------------------
TOPOGRAPHY ICD   CODE        TDXID  :------
TOPOGRAPHY DIAGNOSIS         TDXLIT :--------------------------------
DATE OF DIAGNOSIS            DTDX   :yyyymmdd
INSTITUTION REPORTING DX     INST   :--
DISEASE CATEGORY NUMBER      DISNO  :---
DISEASE CATEGORY LITERAL     DISLIT :---
         DO NOT WRITE INTO THESE FIELDS. FOR INFORMATION ONLY
POINTER TO SPECIAL TERMS     SPECPTR:-----
POINTER TO DISEASE CATEGORYCATPTR :-----  PRESS F5 FOR SUMMARY
```

Within this option the items needed for the completion of the above record will be requested by the program and not filled out directly into the Patient/Diagnosis record.

The program first requests the "the official date of the diagnosis" . Remember that this date becomes the permanent key for linking the Follow-up records, Joint Commission records, and any Disease Specific records and should not be changed once it is entered.

(Screen 37)

```
ENTER OFFICIAL
DATE OF THIS
PATIENT DIAGNOSIS
RECORD
yyyymmdd
```

A scrolling screen appears allowing the user to select the Disease Category for the desired diagnosis.

1.211 Making a Morphologic Diagnosis
The program first seeks a Morphologic Diagnosis. It requests the source of this diagnosis as either from the Dictionary or from the Keyboard.
A. "From the Dictionary"-- The scrolling screen then appears showing a list of acceptable diagnoses for the Disease Category selected. If the Morphology Diagnosis is selected, then it will be entered into the Patient/Diagnosis record along with code. If no selection is made the user should strike ESCape in which case the user will have the option of either returning to menu of going to Keyboard entry of the diagnosis below.

The program then requests the rest of the information needed to complete the new Morphology dictionary record.

(Screen 40)

```
ENTER NAME FOR SCATTERED LIST OF TOPOGRAPHIC
 SITES FOR THIS MORPHOLOGIC DIAGNOSIS. IF A
SEQUENTIAL LIST OF TOPOGRAPHIC SITES IS USED
THEN LEAVE THIS BLANK
                    ----------
```

If a scattered (discontinuous) list of topographic diagnoses is to be used with this morphologic diagnosis, then a unique name for this list is entered here. It is the responsibility of the Data Manager to create this list in the General Terms file (GENTERMS). If a continuous list of topographic diagnoses is to be used, then this screen should be left blank.

If a continuous list of topographic diagnoses is to be used then the next screen requests the stop and start codes indicating the limits of the list in the dictionary. It is the responsibility of the Data Manager to see that these diagnoses exist in the topography dictionary.

(Screen 41)

```
ENTER KNOWN TOPOGRAPHY CODES FOR THE START
AND STOP LIMITS RELATED TO THIS MORPHOLOGY
                DIAGNOSIS

              START CODE ■■■■
              STOP CODE  ■■■■
 IF THERE IS ONLY ONE TOPOGRAPHIC CODE THE
   SAME NUMBER GOES INTO START AND STOP
```

B. "From the Keyboard"--A screen will appear asking if you know the correct ICD code and name of the new diagnosis you wish to use.

(Screen 44)

```
FOR ADDING A NEW DIAGNOSIS AT THIS
POINT YOU EITHER HAVE THE NEW ICD
MORPHOLOGY AND TOPOGRAPHY CODES AT
HAND OR NOT. INDICATE THIS
 1 = ICD CODE KNOWN
 2 = ICD CODES NOT KNOWN. USE
     TEMPORARY CODES
                #
```

a) If the correct ICD code is known the input form for the Morphology Dictionary record appears and should be filled in:

(Screen 16)

```
                        Morphology Record
                    ----------------------------
MORPHOLOGY ICD CODE        MCODE  :------
MORPHOLOGY DIAGNOSIS       TMLIT  :--------------------------------
START TOPOGRAPHY CODE      TPSTART:----
STOP TOPOGRAPHY CODE       TPSTOP :----
KEY COLLATING TOPOGRAPHY   INTLST :----------
DISEASE CATEGORY CODE      CAT    :<<<#
DISEASE CATEGORY LITERAL   CATLIT :--------------------------------
                           PRESS F1 FOR HELP
```

The items marked START and STOP refer to the start and stop codes in the topography dictionary for a continuous list of topographic diagnosis that are appropriate for this particular morphologic diagnosis. If there is only one item in the list the the stop and start codes should be the same. If a discontinuous list of topographic diagnoses is needed then these two items should be left blank and the next item, KEY COLLATING--- should contain the data name for a list of discontinuous ICD topographic codes. It is the responsibility of the data manager to see that this new list of discontinuous topography codes is added to the General Terms file (Paragraph 5.4)

b) If the ICD code is not known, a screen requesting a new temporary morphology diagnosis name and displays a temporary ICD code beginning with the letter M.

(Screen 39)

```
ENTER NEW TEMPORARY MORPHOLOGY
DIAGNOSIS FROM KEYBOARD
THE TEMPORARY MORPHOLOGY CODE IS
M---
--------------------------------
```

The program will then ask if you wish to enter a topographic diagnosis at this time.

(Screen 36)

```
                    ENTER
0 = ADD OR UPDATE TOPOGRAPHIC DIAGNOSIS
1 = UPDATE ENTIRE PATIENT
    DIAGNOSIS RECORD
2 = NO CHANGE NEEDED IN
    TOPOGRAPHIC DIAGNOSIS
```

Explanation of options

0 will send the program to procedures in Paragraph 1.312 below

1 will bring up the entire patient diagnosis record for addition of topography or simply viewing or making other changes in the record. (See Screen 4, Paragraph 1.31 above)

1.212 Making a Topographic Diagnosis. The proedures here are very similar to those above for Morphologic Diagnosis entry into the patient diagnosis record. The screen appears listing the options for selecting the topographic diagnosis

(Screen 45)

```
SOURCE OF TOPOGRAPHIC DIAGNOSIS

0 = TOPOGRAPHIC DIAGNOSIS HAS
    ALREADY BEEN ENTERED. RETURN

1 = ENTER TOPOGRAPHY FROM KEYBOARD

2 = ENTER TOPOGRAPHY FROM DICTIONARY
                    #
```

A. Search the dictionary for topographic diagnosis. A scrolling screen will appear with the list of topography diagnoses that are authorized for the

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particular morphologic diagnosis which is current at this time. If the desired topographic diagnosis is in the list it can be selected by moving the cursor and striking ENTER. If the desired diagnosis is not on the list, only the ESCape button is struck. The program will then go to the keyboard input procedure below (B).

B. Enter Topography diagnosis from the keyboard. The following screen appears.

(Screen 44)

```
FOR ADDING A NEW DIAGNOSIS AT THIS
POINT YOU EITHER HAVE THE NEW ICD
MORPHOLOGY AND TOPOGRAPHY CODES AT
HAND OR NOT. iNDICATE THIS
 1 = ICD CODE KNOWN
 2 = ICD CODES NOT KNOWN. USE
     TEMPORARY CODES
                #
```

a) If the correct ICD code is known the input form for the topography dictionary appears and should be filled in

(Screen 17)

```
                Topography Dictionary Record
TOPOGRAPHY ICD CODE   TPDXID:----
TOPOGRAPHY DIAGNOSIS  TPLIT :--------------------------------
```

b) If the correct ICD code or diagnosis is not known the program will create a temporary ICD code and you may enter the new diagnosis name

(Screen 46)

```
ENTER NEW TEMPORARY TOPOGRAPHY
  DIAGNOSIS FROM THE KEYBOARD
THE TEMPORARY TOPOGRAPHY CODE IS
              T---
 -------------------------------
```

SEVERAL RECORDS MUST BE LINKED TO THIS PATIENT DIAGNOSIS RECORD. THESE ARE :

DISEASE SPECIFIC RECORD
PATIENT FOLLOW-UP RECORD
JOINT COMMISSION EVALUATION RECORD

THERE MAY BE NONE OR SEVERAL OF EACH OF THESE LINKED

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TO A GIVEN PATIENT DIAGNOSIS RECORD. IN EACH CASE THE PROGRAM WILL GO THROUGH A SIMILAR PROCEDURE TO INSURE THIS LINK.

1. WHEN ONE OF THE ABOVE RECORDS IS REQUESTED FOR NEW RECORD, VIEW OR UPDATE THE PROGRAM WILL DISPLAY A SCROLLING SCREEN SHOWING THE PATIENT DIAGNOSES RECORD FOR THE CURRENT PATIENT. THE USER MUST THEN SELECT ONE FOR THE LINKAGE. IF NONE IS SELECTED THE PROGRAM WILL DIRECT THE USER TO MAKE A NEW PATIENT DIAGNOSIS RECORD.

2. THE PROGRAM WILL THEN DISPLAY THE SELECTED PATIENT DIAGNOSIS RECORD FOR VERIFICATION

3. THE PROGRAM WILL THEN ASK THE USER IF THIS IS THE CORRECT PATIENT DIAGNOSIS RECORD.

(Screen 38)

```
IS THIS THE CORRECT PATIENT
     DIAGNOSIS RECORD?
     0 = NO ;  1 = YES
            #
```

IF THIS IS THE CORRECT PATIENT DIAGNOSIS RECORD TO LINK TO, THEN THE PROCEDURES BELOW FOR ENTRY OF DATA INTO ONE OF THE ABOVE LINKED RECORDS WILL CONTINUE. IF IT IS INCORRECT THE PROGRAM RETURNS TO MENU.

THESE PROCEDURES MAY SEEM A BIT CLUMSY BUT ARE NECESSARY TO INSURE CORRECT RECORD LINKAGE.

1.3 "Edit/View/Enter Follow-up Data" - Follow-up data must be linked to a specific Patient/Diagnosis record. Therefore before processing such a record the appropriate Patient/Diagnosis record must be selected.

A screen giving instructions for this record will be displayed.

(Screen 47)

```
        PROCESS FOLLOW-UP SCREEN
Correct Patient master record must
be current. Record must be linked
to a PATIENT/DIAGNOSIS record. This
must be selected as follows:
    INSTRUCTION FOR SELECTING
    PATIENT DIAGNOSIS RECORD
Scroll to Patient Diagnosis record
 If not Found then Strike ESCape
 If Found then Strike Enter
Record will Appear for Viewing
     Then Strike ESC to
   Make the Record Current     #
```

A scrolling screen showing existing follow-up records for the current patient is displayed and a record can be selected. If no record is selected a new record is created for follow-up.

The program will ask if you wish to make a new follow-up record or update an existing record. If the latter is selected a scrolling screen appears showing existing record for the patient and if a selection is made the record will be displayed for update. Else the form will be displayed for input.
The input form for follow-up record is displayed.

(Screen 6)

```
                    Update Patient Follow_up Record (Linked to xxx.xxx)
                    ------------------------------------
PATIENT ID NUMBER                                   PTID      :----------
INSTITUTIONAL IDENTIFICATION NUMBER                 INSTID    :----
DATE OF THIS FOLLOW-UP yyyymmdd                     DTFU      :yyyymmdd
PATIENT VITAL STATUS                                PT_STATUS :--
  (2 = Dead; 1 = Alive; 9 = Unknown
DATE OF DEATH yyyymmdd                              DOD       :yyyymmdd
WAS AUTOPSY PERFORMED                               AUTOPSY   :-
  (2 = No; 1 = Yes; 9 = Unknown
CAUSE OF DEATH CODE                                 COD       :-
  (Use 4 digit code from ICD 9 to record cause of death DAM 3.128)
FUNCTIONAL STATUS                                   FUNCT_STAT:----
  (1 = Normal activity; 2 = Symptomatic and Ambulatory;
   3 = Ambulatory more than 50% of the time, nursing care needed;
   4 = Ambulatory less than 50% of the time, nursing care needed;
   5 = bedridden, may need hospitalization; 8 = not applicable,dead;
   9 = Unknown or Unspecified)
TUMOR STATUS                                        TUMOR_STAT:----
  (1 = No evidence of this cancer; 2 = Evidence of this cancer;
   9 = Unknown. Indeterminate whether this cancer is present).
 F1 = Help
 F5 = Summary
```

1.4 "Edit/View/Enter Joint Commission File" -- The procedures with this file are similar to those for the Follow-Up file. This record must be linked to a particular Patient/Diagnosis record. A screen reviewing the instructions for this will be displayed:

(Screen 50)

```
      PROCESS JOINT COMMISSION DATA
    Correct Patient master record must
    be current. Record must be linked
    to a PATIENT/DIAGNOSIS record. This
    must be selected as follows:
        INSTRUCTION FOR SELECTING
        PATIENT DIAGNOSIS RECORD
    Scroll to Patient Diagnosis record
     If not Found then Strike ESCape
     If Found then Strike Enter
    Record will Appear for Viewing
         Then Strike ESC to
       Make the Record Current     #
```

A scrolling screen showing existing joint commission records (JCE) for the current patient is displayed and a record can be selected. If no record is selected

a new record is created for JCE.

The program will ask if you wish to make a new JCE record or update an existing record. If the latter is selected a scrolling screen appears showing existing record for the patient and if a selection is made the record will be displayed for update. Else the form will be displayed for input.
The input form for follow-up Joint Commission is displayed.

(Screen 20)

```
                    Joint Commission Evaluation Form
                    ********************************
PATIENT ID NUMBER          PTID: ****************      PRESS F5 FOR SUMMARY
DATE OF THIS RECORD: yyyymmdd   DATE OF DEATH:yyyymmdd  yyyymmdd
JOINT COMMISSION EVALUATION DATA FOR  DIAGNOSIS DATE: yyyymmdd yyyymmdd
Number of Days in Hospital During First 365 Days After This Diagnosis:<
DATE OF RELAPSE: yyyymmdd yyyymmdd
-------------------------------------------------------------------------
Cause of Early Death | Morbidity During First 365 Days After  Diagnosis
A. This Cancer : #   |     A. Bleeding (Life Threatening)        :#
B. Bleeding    : #   |     B. Infection (Life Threatening)       :#
C. Infection   : #   |     C. Other Cause (Life Threatening)     :#
D. Other Cause : #   |
KEY TO JOINT COMMISSION DATA ENTRIES:   1 = Yes; 2 = No; 9 = DK
            DO NOT WRITE INTO THIS FIELD. FOR INFORMATION ONLY
              POINTER TO PATIENT DIAGNOSIS RECORD  <<,<<#
=========================================================================
```

The date "FOR THIS DIAGNOSIS DATE" must be the same as the date of diagnosis on the linked Patient/Diagnosis record. This can be displayed by pressing F5 for summary.

1.5 "Enter Disease Specific Data" - The record for disease specific data consists of generic data fields which are the same for each disease category. Each is distinguished by a unique set of data item labels for each disease type. The requirements for a disease specific record are:

1. The disease category must be selected from the scrolling screen.

2. The disease specific record must be linked to a specific Patient/Diagnosis Record. The scrolling screen with patient diagnoses appears and the proper record is selected. (See Screen 4, Paragraph 1.21) If the disease specific category type does not match that of the Patient/Diagnosis record an error message appears.

3. The generic form of the disease specific record

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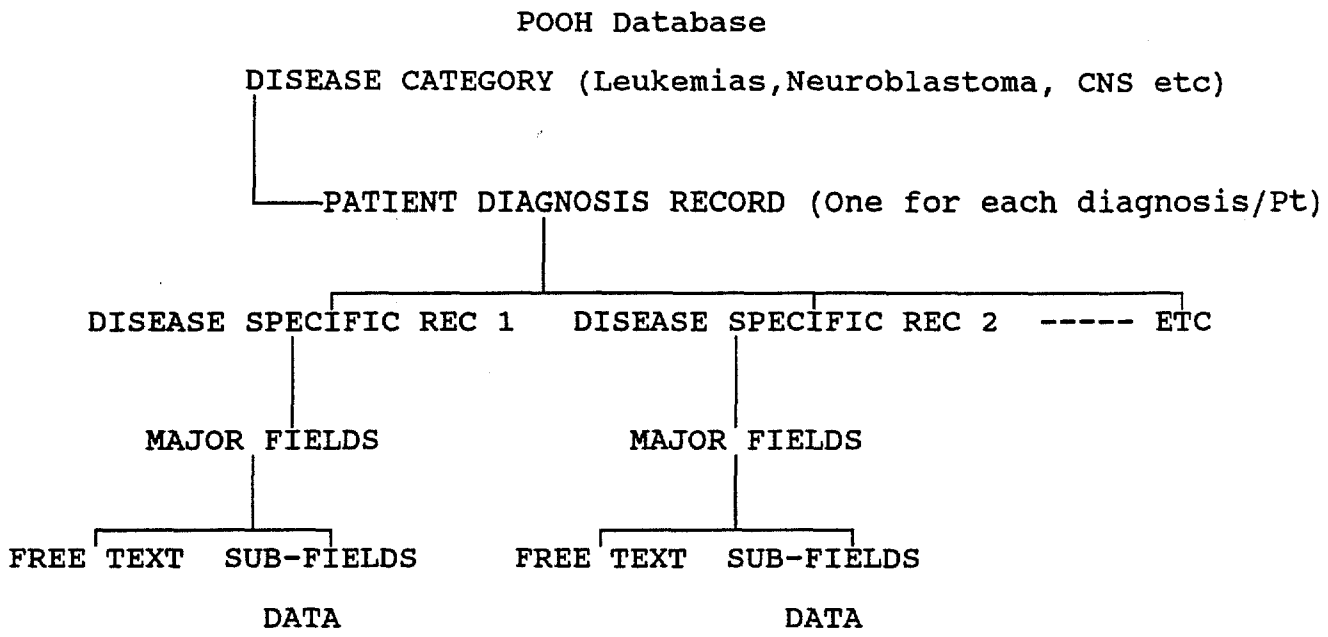
(DISPEC) is as follows:

(Screen 61)

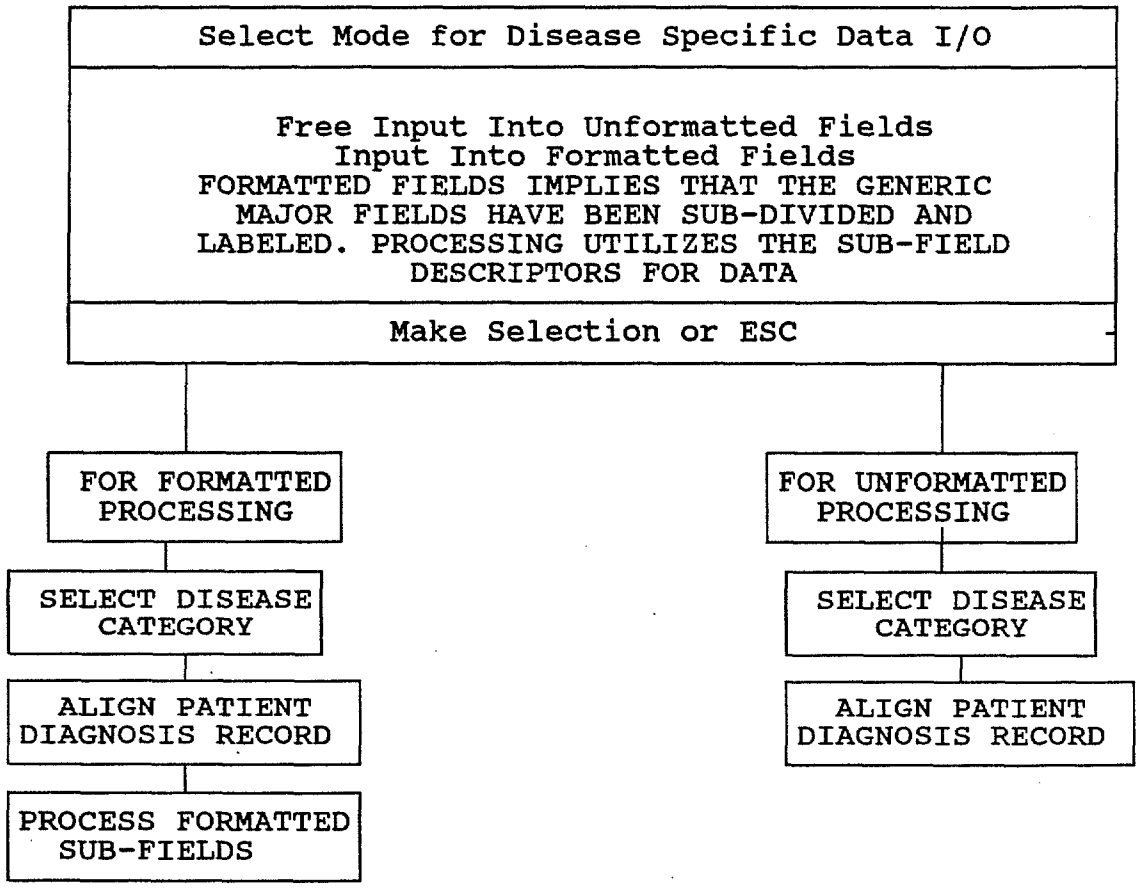
```
                          Disease Specific Record  PT. ID. NO. -----
     INDEX DATE FOR RECORD:yyyymmdd   INDEX CODE FOR RECORD:----------
       DATA LABEL                                  DATA
S01 DATE OF ONSET-----------:yyyymmdd
S02 DATE OF FIRST VISIT-----:yyyymmdd
S03 -------------------------:----------------------------------------
S04 -------------------------:----------------------------------------
S05 -------------------------:----------------------------------------
S06 -------------------------:----------------------------------------
S07 -------------------------:----------------------------------------
S08 -------------------------:--------------------------------
S09 -------------------------:--------------------------------
S10 -------------------------:--------------------------------
S11 -------------------------:--------------------------------
S12 -------------------------:--
S13 -------------------------:--
S14 -------------------------:--
S15 -------------------------:---------------
S16 -------------------------:----------------------------------------
S17 -------------------------:----------------------------------------
S18 -------------------------:----------------------------------------
S19 -------------------------:----------------------------------------
```

The Data Labels are kept in the file = GENTERMS (See Introduction Reference Files). If Formatted Sub-Fields are used, the descriptors for these are kept in file = SPECTRM The option for either formatted or unformatted processing of the Disease Specific Fields is displayed. The major field labels are loaded into the left hand column. The data fields appear in the right hand column and may be either unformatted or subdivided into formatted sub-fields.

There may be more than one disease specific record/patient diagnosis record. The Disease Specific record consists of 19 fixed length text (string) fields with different lengths and two date fields. In the record the fields are given only a generic name (S01-S19). A major field name can be assigned to each text string and is accessed in the GENTERMS file. Input of unformatted text can be entered into each field or the fields can be given a specific data format as sub-fields. The labels for the sub-fields are carried in the SPECTRM file. Thus the logical hierarchy for access to the Disease Specific file is:


POOH Database
DISEASE CATEGORY (Leukemias,Neuroblastoma, CNS etc)
PATIENT DIAGNOSIS RECORD (One for each diagnosis/Pt)
DISEASE SPECIFIC REC 1
DISEASE SPECIFIC REC 2
----- ETC
MAJOR FIELDS
MAJOR FIELDS
FREE TEXT
SUB-FIELDS
DATA
FREE TEXT
SUB-FIELDS
DATA

(screen 68)


Select Mode for Disease Specific Data I/O
Free Input Into Unformatted Fields
Input Into Formatted Fields
FORMATTED FIELDS IMPLIES THAT THE GENERIC MAJOR FIELDS HAVE BEEN SUB-DIVIDED AND LABELED. PROCESSING UTILIZES THE SUB-FIELD DESCRIPTORS FOR DATA
Make Selection or ESC
FOR FORMATTED PROCESSING
SELECT DISEASE CATEGORY
ALIGN PATIENT DIAGNOSIS RECORD
PROCESS FORMATTED SUB-FIELDS
FOR UNFORMATTED PROCESSING
SELECT DISEASE CATEGORY
ALIGN PATIENT DIAGNOSIS RECORD

1.51 "Free Input Into Unformatted Fields" -- The free input into the generic fields of the specific disease record Screen 61 above is requested. The field labels must have already been entered into the General Terms File.

1.52 "Input Into Formatted Fields" -- In this case the generic fields labels must already be in the General Terms File and the Sub-Fields labels and formats must already have been entered into Specific Terms File (SPECTRM).

A screen appears allowing you to cancel formatted input at this point.

(Screen 54)

```
FORMAT EXISTS FOR PROCESSING
----------------------------

IF YOU WISH TO CANCEL FORMATTED
   PROCESSING THEN ENTER 1.
IF YOU WISH TO USE FORMATTED INPUT
        THEN ENTER 0
             #
```

A coded mnemonic name may be entered to identify the disease specific records using the same format. This mnemonic may represent for example PRE-OP, POST-OP etc.

(Screen 60)

```
CREATE CODED MNEMONIC FOR UNIQUE
    DISEASE SPECIFIC RECORD
    -----------------------
```

The program will cycle through the major fields and then each subfield requesting input data and labels. First, the date for the input is requested.

(Screen 55)

```
DISEASE SPECIFIC DATE INPUT/OUTPUT
MAJOR FIELD:--------------------------------
            INPUT DATE FIELD      yyyymmdd
                 yyyymmdd
```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The the data and labels for the major fields are requested.

(Screen 56)

```
LITERAL INPUT FOR DISEASE:----------------------------------------
MAJOR FIELD LABEL        :----------------------------------------
           INPUT MAJOR FIELD LITERAL FOR INDICATED BLANKS
         ------------------------------------------------------------
 INPUT :------------------------------------------------------------
```

The data and labels for the sub-fields are requested
(Screen 57)

```
          I/O WINDOW FOR SPECIFIC DISEASE SUB-FIELD
SPECIFIC DISEASE:-----------------------------------------
MAJOR FIELD     :-----------------------------------------
SUB-FIELD       :-----------------------------------------
CURRENT         :-----------------------------------------
            NEW DATA INPUT MUST FILL ALL BLANKS
         ------------------------------------------------
INPUT   :------------------------------------------------
```

"CURRENT" refers to the current state of the sub-field

1.6 "View Current Patient Summary" -- This displays a scrolling list of Patient/Diagnoses and dates and a list of Follow/up records and dates. This summary may also be called up from various screen by pressing F5 if indicated on the screen.

2.0 "Select Printed Reports" -- Reports referring to a single given patient require that the patient be identified before calling the report. The patient identification should be seen in the lower left line of the screen. A manu listing the report options appears:

(Screen 69)

```
Report Options

Comprehensive Patient Data
REQUIRES THAT VALID PATIENT BE
IDENTIFIED

Topography/Morphology List
Alpha List Report
Follow-Up Report by Patient
Follow-Up Report by Institution
Table of Last Follow-Ups
Joint Commission Report by Patient Name
Print Morphology Dictionary
Print Topography Dictionary
Print Morphology by Categories

Make Selection or Escape
```

The Report Options will display a screen just before printing to prepare the printer. In this version it is assumed that your printer can be programmed from the printer panel. If not, a special printer module will have to be added to your program to accomodate your particular printer.

(Screen 63)

```
INITIALIZE THE PRINTER
Before beginning this report

ALIGN THE PAPER IN THE PRINTER AND SET THE
PITCH AT XX CHARACTERS PER INCH

ENTER 1 TO CONTINUE
#
```

2.1 "Comprehensive Patient Data" -- This report requires the identification of a single patient. A screen appears requesting selection of the types of data to be reported for this patient.

(Screen 62)

Select Basic Parts to Report
Demographic Information Tumor Diagnosis Follow-Up Data Disease Specific Data Formatted
Select Parts to Include in Report and ESC

The cursor can be moved from on item to the next with the cursor keys and the selection can be made by pressing Enter. When all the options which you wish included in the report have been selected, press escape.

The instruction to set up the printer will appear

(Screen 63)

```
   INITIATE REPORT ON CURRENT PATIENT
Before beginning this report the patient
must have been identified from the menu
and the name and number displayed on the
lower left corner of the screen. If this
is not so:
          ENTER 0
Else:
ALIGN PAPER IN THE PRINTER AND SET THE
    PITCH TO 12 CHARACTERS PER INCH
         ENTER 1 TO CONTINUE  #
```

2.2 "Topography/Morphology List" -- This generates a report for all patients in the registry and does not require identification of a patient. The program requests alignment of the paper in the printer and setting of the pitch to 15 characters per inch. The output includes the patient identification data, tumor diagnoses, date of birth and other demographic data for each patient. This is printed out as a two line record for each patient/diagnosis.

2.3 "Alpha List Report" -- This contains the same data as the above report sorted by alaphabetic patients' last name.

2.4 "Follow_up Report by Patient" -- This generates a list of follow-up records on each patient grouped by patient name.

2.5 "Follow-up Report by Institution -- This generates a list of follow-up reports sorted by reporting institution.

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2.6 "Table of Last Follow-ups" -- This generates a table of the last dated follow-up for each patient.

2.7 "Joint Commission Report by Patient Name" --This generates a list of the Joint Commission Evaluation records for each patient

3.0 "Erase Patient Files" -- This allows systematic deletion of selected files. This option requires each time that a patient be identified as indicated by the lower left corner of the screen.
THIS OPTION MUST BE USED WITH GREAT CARE SINCE THE RECORDS WILL BE PERMANENTLY ERASED. (Records can usually be reclaimed by going to the basic CLARION Scanner Facility IMMEDIATELY)

Records must be systematically deleted because of the need to maintain record linkages. The deletion process must start with the lowest level records and proceed upwards. The record heirarchy is:

Patient Master Record
Patient Diagnosis Record
Follow-up Record, Joint Commission Record, Disease Specific Record

When any category of records is selected for erasure it must be remembers that all categories lower than the selected on will also be erased. Each time a category appears for erasure a warning screen appears indicating the category and gives the user the option of cancelling the erasure.

A screen first appears giving the user the choice of options for erasure. IT SHOULD BE REMEMBERED THAT ALL RECORDS IN THE SELECTED CATEGORY FOR THE SELECTED PATIENT WILL BE ERASED.

(Screen 70)

```
SELECT PART OF PATIENT'S RECORDS TO BE ERASED
                FROM THE DATA BASE
   WARNING!!! ERASURES WILL BE PERMANENT
   RECORDS WILL BE DELETED FOR PATIENT:
-----------Patient Name----------------------
1 = ERASE ALL OF CURRENT PATIENT,S RECORDS
2 = ERASE ONLY DIAGNOSIS, FOLLOW-UP, DISPEC,
    JOINT COMMISSION EVALUATION RECORDS
3 = ERASE FOLLOW-UP RECORDS ONLY
4 = ERASE JOINT COMMISSION EVALUATION ONLY
5 = ERASE DISEASE SPECIFIC RECORDS ONLY
                    ENTER #
```

4.0 "Data File Editing Procedures". Selecting this option brings up the screen "Data File Edit Options" which allows the user to select the type of data file to edit. In each of these a scrolling screen for the

requested file will show the records currently in that file. With the cursor keys the user can select any record for updating or deletion or can create a new record for the file. The keys to press to perform each of these operations are described on the screens:

Ins to create a new record
Enter to change an existing record
Del to delete an existing record

The cursor keys that can be used to select a record are:

Up arrow, down arrow, PgUP, and PgDn

When a record is found, select it by pressing Enter or Delete.
To quit the file press ESCape
IT IS RECOMMENDED THAT RECORDS BE DELETED OR CREATED WITH GREAT CARE UNDER THIS OPTION SINCE RECORD LINKAGE MAY BE DESTROYED. Records should be created or deleted under program control where record linkage is automatic. Thus, this option should be used only for viewing files or making minor changes in existing records and accessed only by the Data Manager.

(Screen 9)

Data File Edit Options
View/Edit Patient Master File *View/Edit Patient/Diagnosis File *View/Edit Patient Follow-Up File *View/Edit Joint Commission Evaluation * = RECORDS SHOULD NOT BE ADDED TO THESE FILES FROM THIS MENU
Make Selection or ESC to Return;F1 for Help

4.1 "View/Edit Patient Master File" - The form screen for updating or creating records for the Master File is shown in Screen 3 Paragraph 1.11 above.

4.2 "View/Edit Patient /Diagnosis File" - This file links the patient ID number with a diagnosis. There is one record for each diagnosis on a given patient. This record must exist before a disease specific record, a follow-up, or a JCE record can be created. The pointer is to the disease category record in GENTERMS. The pointer to the disease specific record is not used in this version. (The field POINTER should not be changed by the user) Any new record of this type must be added from the program menu rather than directly under this option. This option should be used only for viewing patient diagnosis

records or changing existing records but not for creating new records because of the need for the program to identify pointers.
The official date of this diagnosis (DTDX) is used as a pointer for linking other records to this diagnosis.
The input screen for this record is shown above, Screen 4 Paragraph 1.21.

4.3 "View/Edit Patient Follow-Up File" - This file contains follow-up data for a given patient for a given diagnosis. The Patient/Diagnosis record must exist before the record in this file can be entered. The pointer must point to the corresponding patient diagnosis record in the file=DXPT. This procedure should not be used for creating a new record but should be used only for updating or viewing. New records should be created under the program menu. The input screen for this record is shown above as Screen 6, Paragraph 1.4.

4.4 "View/Edit Joint Commission Evaluation File" - Contains a check list for Joint Commission evaluation. This record would usually be entered at the end of the first year after diagnosis or sooner if death intervenes. The date of diagnosis should correspond to the date of diagnosis on the linked record for this diagnosis. By pressing F5 when this screen is displayed, the brief summary records containing dates can be displayed for reference. The input form for this record is shown above as Screen 20, Paragraph 1.5.

5.0 "Edit Options - Reference Files" - These files contain data which is stable during tumor data input. These files must be up to date BEFORE TUMOR DATA INPUT is performed. Some updating of the diagnosis dictionaries can be performed during tumor data input, but for the most part, these files should be updated before tumor data input. The files marked with the * should only be selected by the programmer for changes or additions. The menu for selection is shown:

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(Screen 10)

```
Edit Options -- Reference Files
List of Reporting Institutions
* Edit Outline Table
* Edit Labels Table
* Edit General Terms Dictionary
Edit Morphology Dictionary
Edit Topography Dictionary
* Edit Special Terms File
Add New Morphology Codes to Dictionary
* = CHANGES SHOULD BE MADE ONLY BY PROGRAMMER
Make Selection or ESC to Continue; F1 for Help
```

5.1 "List of Reporting Institutions" - These records contain the demographic information for each reporting institution, such as address, person of contact, and code numbers. The institutional code is an arbitrary unique code determined by the Project Manager. The input for this record is shown as Screen 18,Paragraph 1.11

5.2 "Edit Outline Table" - This is to be used only by the programmer. It contains information for scrolling screens.

5.3 "Edit Labels Table:" - This is to be used only by the programmer. It contains labels for screens.

5.4 "Edit General Terms Dictionary" - This is to be used only by the programmer. It contains lists of terms to be displayed. The format is shown:

(Screen 13)

```
Update General Terms
---------------------------
ITEMNO :-----
COLLATE:----------
DISNO  :---
TYPENO :----
FLDNO  :---
ICD    :--------
TERM   :--------------------------------
LIM1   :----------
LIM2   :----------
FORMAT :--
```

5.5 "Edit Morphology Dictionary" --(TMDICT) This contains the list of Morphology Diagnosis and ICD code for each. The

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description of fields in this record are found in Paragraph 1.21 above and the input Screen 16 in the same place. For the Morphology terms the standard ICD M format is used. The first 4 digits represent the morphology of the tumor. The fifth space is for the slash (/). The sixth space is a code for the behavior of the tumor:

/0	benign
/1	borderline malignancy
/2	carcinoma in situ, non invasive
/3	malignant, primary site
/4	malignant secondary site
/5	malignant, uncertain primary vs secondary

5.6 "Edit Topography Dictionary" -- (TPDICT). This contains a list of topography diagnoses and the ICD codes. The input screen is Screen 17 in Paragraph 1.212 above.
The standard ICD C format is used. The code consists of two digits, a decimal point, and another digit, for example XX.X. In these programs the preceding letter "C" is not used.

5.7 "Edit Special Terms File -- (SPECTRM)
(See INTRODUCTION above "Data Files" par.7)
This should be used to set up or alter the records in the Special Terms File (SPECTRM) which contain information for the descriptors of the sub-fields in the DISPEC file. To describe the sub-fields under a designated major field, the following order of messages is needed:

1. Introductory record for the major field
2. Index record for each sub-field
3. Descriptor record for each sub-field

The input screen for each of these records is as follows:

(Screen 14)

```
                    Update Specific Disease Fields
                    ------------------------------
SPECIFIC DISEASE CATEGORY NO CAT    :---
MAJOR FIELD NUMBER           FLDNO  :---
NUMBER OF SUB-FIELDS/FIELD   NOSFLD :---
SUB-FIELD INDEX NUMBER       SFLDNO :---
SUB-FIELD LENGTH             SFLDLGT:---
BEGINNING BYTE FOR SUB-FIELD BASFLD :---
CONVERSION OF STRING TO *    CVSFLD :---
SUB-FIELD LABEL              SFLDLBL:--------------------------------
*CONVERT TO:0=STRING;1=BYTE;2=SHORT;3=LONG;4=DATE;5=DECIMAL;6=FREE
```

The conversion codes are used for special data conversion types. All are assumed to be 0=string unless otherwise specified. The only special types which are programmed in this version are

4 = DATE in format yyyymmdd and 6 = FREE STRING for comment fields.

A typical set of records for describing sub-fields in the major fields of NEUROBLASTOMA (18) is as follows:

CAT	FLDNO	NOSFLD	SFLDNO	SFLDLGT	BASFLD	CVSFLD	SFLDLBL
18	0	0	0	0	0	0	NEUROBLASTOMA
18	1	1	0	0	0	4	DATE OF ONSET (Index)
18	1	1	1	0	0	4	DATE OF ONSET (Descriptor)
18	2	1	0	0	0	4	DATE OF FIRST VISIT
18	2	1	1	0	0	4	DATE OF ONSET
18	3	10	0	0	0	0	CLINICAL MANIFESTATIONS
18	3	10	1	1	1	0	ABDOMINAL MASS 0/1
18	3	10	2	1	2	0	ABDOMINAL PAIN 0/1
18	3	10	3	1	3	0	RESPIRATORY DISTRESS 0/1

.
.
.
.
ETC

These records when completed will be used by the data input and retrieval from the sub-fields.

5.8 "Add New Morphology Codes to Dictionary -- This allows a programmed creation of new records in this file and should be used rather than direct input as in Paragraph 5.5 above.

6.0 "Create Disease Specific Sub-Fields" -- In this version this should be carried out under "Edit Special Terms File" as in Paragraph 5.7 above.

7.0 "Rectify Temporary Diagnosis Codes" -- When diagnoses are entered from the keyboard and the ICD code is not known, (Paragraph 1.211 B, above) the program assigns a temporary "ICD" number beginning with either "M" for morphology or "T" for topography. These diagnoses are stored in the respective dictionary. Since these temporary codes do not receive full service from the rest of the program, they should be rectified as soon as possible to the correct ICD codes and terminology.

A screen appears requesting which file to rectify

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(Screen 71)

Select Dictionary to Rectify
Rectify Temporary Morphology Codes Rectify Temporary Topography Codes (THE SECOND OPTION ABOVE SHOULD ONLY BE USED AFTER THE FIRST OPTION HAS BEEN RUN)
Make Selection or ESCape

The second option above is used only to rectify any topography diagnoses that have not been rectified by the first option. It should rarely be used.

The program accomplishes this by reading through the respective dictionary and detecting any of the temporary codes. When a temporary code is detected a screen will appear showing the temporary code and awaiting input of the correct code.

(Screen 52)

```
          TEMPORARY CODE DETECTED IN MORPHOLOGY DICTIONARY
CODE      :----
DIAGNOSIS :-----------------------------
                    ENTER PERMANENT CODE AND DIAGNOSIS
CODE      :------
DIAGNOSIS :---------------------------------
```

When this occurs and the user writes in the correct data then:

1) The morphology dictionary item is corrected
2) The patient diagnosis record bearing the temporary code is corrected
3) The topography dictionary is searched for a corresponding temporary code and the same procedure followed for correcting the topography dictionary and patient diagnosis record.

(Screen 53)

```
          TEMPORARY CODE DETECTED IN TOPOGRAPHY DICTIONARY
CODE      :----
DIAGNOSIS :------------------------------
                    ENTER PERMANENT CODE AND DIAGNOSIS
CODE      :------
DIAGNOSIS :---------------------------------
```

8.0 Creation of Survival Curves. This program when selected will create the ASCII file containing the survival data under the DOS name of TRPOOH.DOS. This file should be looked at under the DOS EDIT and all quotation marks removed by the editor before running the statistics program. This may vary with different editors.
After this file is generated the user should EXIT from the TUMOR program and then call the program = TRSTAT from DOS to actually generate the survival curves. The instruction for using this program are self explanatory on the screen. (This program is developed by Mr Ed Brown, Kansas University Medical Center in the Department of Biometry)

POOH CANCER DATA ABSTRACTING AND CODING MANUAL*
(For use with the POOH Tumor 6.10 Registry Program)

*With excerpts from the American College of Surgeons' Data Acquisition Manual, copyright 1988.

Manual by: Cathy D. Boysen, University of Kansas Medical Center

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D. Completing the POOH Joint Commission Evaluation Record 16

I. General instructions

- Use No. 2 soft lead pencil to record data on the forms.
- Print one letter or digit in each box provided.
- Use the coding books and lists indicated as sources of codes for:

  institution code
  race/ethnicity code
  sex code
  state abbreviation
  country geocode
  disease specific categories
  morphology diagnoses and codes
  topography diagnoses and codes
  vital status code
  autopsy code
  cause of death code
  functional status code
  tumor status code
  cause of early death
  morbidity after diagnosis

- Confer with your Data Manager when you encounter questions or problems.

POOH PATIENT MASTER RECORD

Institution: _____

PATIENT ID NUMBER:

|_|_|_| / |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Institution #/ Chart or ID Number

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Patient Last Name

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Patient First Name

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Patient Middle Name

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Mother Last Name (Maiden)

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Mother First Name

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Mother Middle Name

PATIENT DATE OF BIRTH:

|_|_|_|_| / |_|_| / |_|_|

Year Month Day

DATE OF DIAGNOSIS:

|_|_|_|_| / |_|_| / |_|_|

Year Month Day

RACE/ETHNICITY:

|_|_|

(01=White 02=Black 03=Asian 04=Hispanic
05=Amerind, Aleut, Eskimo 06=Gypsy 98=Other 99=DK)

SEX:

|_|

(1=Male 2=Female 3=Other 9=DK)

II. Line by line abstracting and coding instructions

A. Completing the POOH Patient Master Record

The POOH Patient Master Record is a two page form containing demographic information on the patient and the patient's original date of cancer diagnosis. The following instructions should assist the data abstractor and coder with completing this form.

Page 1 of Master Record

Institution = the hospital responsible for the patient's care. At present, four institutions are listed in the POOH Tumor5.1 Registry program:

001 = Kansas University Medical Center, Kansas City, Kansas
002 = Semmelweis University Medical School, Budapest, Hungary
003 = National Institute of Neurosurgery, Budapest, Hungary
004 = Kyrgyz Institute of Oncology and Radiology, Bishkek, Kyrgyzstan

Patient ID Number = uniquely identifies each patient in the registry. This number consists of two parts:

Part 1 = the 3 digit institution code corresponding to the institution responsible for the patient's care.
Part 2 = the 7 digit hospital chart number listed on the patient's Kansas University Medical Center hospital chart or the 11 digit social security number used to identify individuals in Hungary.

Patient Name = the last, first, and middle given name of the patient. When Jr. or other designators are used with a name, list this after the first name. (Example: Mark Jr. or John III)

Mother Name = the maiden, first, and middle name of the biological or adoptive mother of the patient.

Patient Date of Birth = the legal birthdate of the patient. Note that throughout the registry system, dates are listed as 4 digit year, then 2 digit month, and 2 digit day. A zero must precede single-digit months and days.

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Month	Day	Year
01 - January	01	Use 4 digit year
02 - February	02	9999 Year unknown
03 - March	03	
04 - April	..	
05 - May	..	
06 - June	25	
07 - July	..	
08 - August	..	
09 - September	31	
10 - October	99 Day unknown	
11 - November		
12 - December		
99 - Month unknown		

(Example: January 5, 1978 would be coded as: 19780105).

Approximation is preferable to coding year unknown. When the exact birthyear is unknown, an estimate should be made. For example, if the patient is 10 years old when admitted to the hospital on July 18, 1990, and no birthdate is given, record 19809999.

Date of Diagnosis = the date the patient's first cancer is diagnosed by a recognized medical practitioner. Patients may have multiple primary cancers, but this date on the Master Record will always remain the same and indicate the date the original cancer was diagnosed.

The date of diagnosis is often a clinical diagnosis and may never be confirmed histologically. Even if confirmed later, this item refers to the date of the first clinical diagnosis and not to the date of confirmation.

If upon medical or pathologic review of a previous condition, the patient is deemed to have had cancer at an earlier date, the earlier date is the date of diagnosis. As such, the date of initial diagnosis is then back dated.

Month	Day	Year
01 - January	01	Use 4 digit year
02 - February	02	9999 Year unknown
03 - March	03	
04 - April	..	
05 - May	..	
06 - June	25	
07 - July	..	
08 - August	..	
09 - September	31	
10 - October	99 Day unknown	
11 - November		
12 - December		

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RESIDENCE:

Street, P.O. Box, Apt. #

City

State

Zip or Postal Code

Country

Father Last Name

Father First Name

Father Middle Initial

BIRTHPLACE:

City of Birth

State of Birth

Country

Zip or Postal Code

99 - Month unknown
(Example: January 5, 1978 would be coded as: 19780105).

If the exact date of diagnosis is not known, the best estimate based on available information is acceptable. Approximation is preferable to recording the date unknown.

a. For a case diagnosed before a patient entered the hospital, such as in a clinic or physician's office, the date of first hospital admission may be used if it seems that the patient was hospitalized within one month from the true date of diagnosis by the referring physician.

b. If the only information is spring, middle, or fall of the year, approximate these as April, July, or October, respectively. For winter of, it is important to discern whether the beginning or the end of the year is meant before estimating the month.

c. If there is no basis for approximation, code the month 99.

d. If necessary, estimate the year. If approximation is impossible, code the year of diagnosis as 9999.

e. The date of first cancer-directed therapy may be used as the date of diagnosis if the cancer-directed therapy was initiated prior to the definitive diagnosis of cancer, which was later confirmed.

Race/Ethnicity = the patient's primary race or ethnicity should be indicated using the appropriate two digit code. Currently, these codes are as follows:

01 = White or Caucasian
02 = Black or Afro American
03 = Asian or Oriental
04 = Hispanic
05 = Amerind, American Indian, Aleut, or Eskimo
06 = Gypsy
98 = Other
99 = Don't Know

Sex = the sex of the patient. A one digit code should be used to indicate patient sex as indicated below:

1 = Male
2 = Female
3 = Other
9 = Don't Know

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Page 2 of Master Record

Residence = the permanent residence of the patient. Street, P.O. Box, and/or apartment number should be listed on the first line. City should be indicated on the second line and two letter abbreviation corresponding to the state should be recorded on the third line (see state codes list, Appendix A).

The U.S.A. 5 digit zip code is to be recorded in the first 5 boxes of the zip code field. The Hungarian 4 digit postal code or the 4 digit zip code extension (when available) should be listed in the last four boxes of the zip code field. (Examples: Code 66160, U.S.A zip code as 6/6/1/6/0-_/_/_/_; code 66160-9543, U.S.A. zip code as 6/6/1/6/0-9/5/4/3; code 4567, Hungarian postal code as _/_/_/_/_ - 4/5/6/7).

The 3 digit country code corresponds to the country of residence and should be derived from the country geocodes list found as Appendix B. (Examples: U.S.A. = 926, Hungary = 445).

Father Name = the last, first, and middle name of the biological or adoptive father of the patient.

Birthplace = the place of birth of the patient. City should be indicated on the first line and the two letter abbreviation corresponding to the state should be recorded in the state of birth field on the second line.

The 3 digit country code corresponds to the country of residence and should be derived from the country geocodes list found as Appendix B. (Examples: U.S.A. = 926, Hungary = 445).

The U.S.A. 5 digit zip code is to be recorded in the first 5 boxes of the zip code field. The Hungarian 4 digit postal code or the 4 digit zip code extension (when available) should be listed in the last four boxes of the zip code field. (Examples: Code 66160, U.S.A zip code as 6/6/1/6/0-_/_/_/_; code 66160-9543, U.S.A. zip code as 6/6/1/6/0-9/5/4/3; code 4567, Hungarian postal code as _/_/_/_/_ - 4/5/6/7).

POOH DIAGNOSIS RECORD

PATIENT ID NUMBER:

___ ___ ___ / ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

PATIENT NAME:

LAST FIRST MIDDLE

Disease Specific Category

Reporting Institution

Morphology Diagnosis

/

Morphology Code

Date of Diagnosis:

/ /

Year Month Day

Topography Diagnosis

.

Topography Code

B. Completing the POOH Diagnosis Record

The POOH Diagnosis Record is a one page form used for recording patient cancer diagnosis information. The following information should assist the abstractor or coder in its completion.

Patient ID Number = uniquely identifies each patient in the registry. This number consists of two parts:

Part 1 = the 3 digit institution code corresponding to the institution responsible for the patient's care.
Part 2 = the 7 digit hospital chart number listed on the patient's Kansas University Medical Center hospital chart or the 11 digit social security number used to identify individuals in Hungary.

Patient Name = the last, first, and middle given name of the patient. When Jr. or other designators are used with a name, list this after the first name. (Example: Mark Jr. or John III)

Disease Specific Category = one of eleven categories for classifying cancer types. Each cancer type is contained under one of these eleven categories. Use the complete list of cancer types provided in Appendix B to determine the correct disease specific category to record on the form. The eleven disease specific categories include:

Leukemias
Non-Hodgkin's lymphoma
Wilm's tumor
Neuroblastoma
Bone and joint tumors
Ewing's sarcoma
Rhabdomyosarcoma
Central nervous
Other rare tumors
Retinoblastoma

Reporting Institution = the hospital responsible for making this diagnosis. Fill in the three digit code that corresponds to the appropriate institution. At present, four institutions are listed in the POOH Tumor5.1 Registry program:

001 = Kansas University Medical Center, Kansas City, Kansas
002 = Semmelweis University Medical School, Budapest, Hungary
003 = National Institute of Neurosurgery, Budapest, Hungary
004 = Kyrgyz Institute of Oncology and Radiology, Bishkek, Kyrgyzstan

Morphology Diagnosis = the histological name of the tumor that was diagnosed. Print in the complete name of the morphology in the boxes provided. When it is unclear from the clinical, pathology or cytology report how a tumor should be classified, consult with your Data Manager.

Morphology Code = corresponds to the morphology diagnosis and should only be derived from the International Classification of Diseases for Oncology, second edition, World Health Organization, 1990. When it is unclear from the clinical, pathology or cytology report how a tumor should be classified, consult with your Data Manager.

All pathology reports for the particular primary site should be reviewed. Although the material from the most representative tissue is usually the best, sometimes all of the positive material may be removed at biopsy.

> Example: The pathology report from a skin biopsy states superficial malignant melanoma. At wide excision, no residual tumor was found. The histology would be coded as superficial malignant melanoma (8720/3).

Usually the FINAL pathologic diagnosis is coded. However, if the final diagnosis is carcinoma, NOS; melanoma, NOS; sarcoma, NOS; lymphoma, NOS; or malignant tumor, NOS; AND a more specific detailed histology (a higher ICD-O code) is found in the microscopic description or in a comment, the more specific histologic diagnosis should be coded.

> Example: The final pathologic diagnosis is histiocytic lymphoma (9680/3). The comment states either diffuse large cell (9680/3) or large cell immunoblastic (9684/3). The final diagnosis, histiocytic lymphoma (9680/3) is coded because it is specific. Ignore the statement of immunoblastic in the comment.

For purposes of coding, the term "different histologies" refers to a difference in the first three digits of the histology code. However, the behavior code (fifth digit) should always be considered.

If there are two histologies in the same lesion and the behavior code is the same, select the higher histology code if no combined code exists. For example:

> Biopsy: Squamous cell carcinoma (8070/3)
> Surgery: Squamous cell carcinoma, keratinizing type (8071/3)
> Code to the higher morphology: (8071/3)

or

Pathology report: Transitional cell epidermoid carcinoma
Transitional cell carcinoma, NOS has a code of 8120/3 and epidermoid carcinoma, NOS has a code of 8070/3. Code this case to the higher code (8120/3).

If a combined histology code exists, select the combination code. For example:

Pathology report: Mixed adenocarcinoma and squamous cell carcinoma
Code to the combination code for adenosquamous carcinoma (8560/3)

If the behavior code is not the same, select the morphology code of the higher behavior code (invasive tumor). For example:

Pathology report: Invasive carcinoma (8010/3)
Pathology report: Squamous cell carcinoma in situ (8070/3)
Code to invasive tumor (8010/3)

If no tissue or cytology specimen was obtained for a diagnosis of malignancy, use the code numbers listed under 800-Neoplasms, NOS. If the physician is more specific, use the more specific histology code.

For more information on coding histologic type of tumor, refer to the International Classification of Diseases for Oncology, 1990 (ICD-O).

Date of Diagnosis = the date this cancer was diagnosed by a recognized medical practitioner.

The date of diagnosis is often a clinical diagnosis and may never be confirmed histologically. Even if confirmed later, this item refers to the date of the first clinical diagnosis and not to the date of confirmation.

If upon medical or pathologic review of a previous condition, the patient is deemed to have had cancer at an earlier date, the earlier date is the date of diagnosis. As such, the date of initial diagnosis is then back dated.

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Month	Day	Year
01 - January	01	Use 4 digit year
02 - February	02	9999 Year unknown
03 - March	03	
04 - April	..	
05 - May	..	
06 - June	25	
07 - July	..	
08 - August	..	
09 - September	31	
10 - October	99 Day unknown	
11 - November		
12 - December		
99 - Month unknown		

(Example: January 5, 1978 would be coded as: 19780105).

If the exact date of diagnosis is not known, the best estimate based on available information is acceptable. Approximation is preferable to recording the date unknown.

a. For a case diagnosed before a patient entered the hospital, such as in a clinic or physician's office, the date of first hospital admission may be used if it seems that the patient was hospitalized within one month from the true date of diagnosis by the referring physician.

b. If the only information is spring, middle, or fall of the year, approximate these as April, July, or October, respectively. For winter of, it is important to discern whether the beginning or the end of the year is meant before estimating the month.

c. If there is no basis for approximation, code the month 99.

d. If necessary, estimate the year. If approximation is impossible, code the year of diagnosis as 9999.

e. The date of first cancer-directed therapy may be used as the date of diagnosis if the cancer-directed therapy was initiated prior to the definitive diagnosis of cancer, which was later confirmed.

Topography Diagnosis = the primary site of the cancer. This item identifies the site of origin of a tumor. Print in the complete topographical description in the boxes provided. When the primary site is unclear from the clinical, pathology or cytology reports, consult with your Data Manager.

Topography Code = the three digit code that corresponds with the primary site of the cancer.

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The topography section of the ICD-O should be used for coding the primary site of all tumors. The site codes may be found in the Topography, Numerical List section (pages 1 - 20) or in the Alphabetic Index (pages 51 - 136), which includes both topography and morphology terms. In the Alphabetic Index, all site (topography) codes are indicated by a "C" preceding the code number. (Note: The "C" is not coded).

Leukemia is coded to bone marrow (42.1), because blood cells originate in the bone marrow.

Both Hodgkin's and non-Hodgkin's lymphomas should be coded to the lymph nodes, NOS (77.9) for this project.

POOH FOLLOW-UP RECORD

PATIENT ID NUMBER: _____

PATIENT NAME: _____
LAST FIRST MIDDLE

MORPHOLOGY CODE: _____

MORPHOLOGY: _____

TOPOGRAPHY CODE: _____

TOPOGRAPHY: _____

DATE OF DIAGNOSIS: _____

Reporting Institution: [ ][ ][ ]

Date of this follow-up: [ ][ ][ ][ ] / [ ][ ] / [ ][ ]
Year Month Day

Patient Vital Status: [ ] (1=Alive 2=Dead 9=Unknown)

<u>If Deceased:</u>

Date of Death: [ ][ ][ ][ ] / [ ][ ] / [ ][ ]
Year Month Day

Was autopsy performed? [ ] (1=Yes 2=No 9=Unknown)

Cause of Death: [ ][ ][ ][ ] (ICD-9-CM)

Tumor Registry Code for Cause of Death: [ ]

0 = Dead, Cause: Other Than Cancer
1 = Dead, Cause: Cancer Coded Here
2 = Dead, Cause: Cancer Other Than This Cancer
3 = Dead, Cause: Unknown

Patient Functional Status: [ ]

1=Normal Activity
2=Symptomatic and ambulatory
3=Ambulatory more than 50% of the time, occasionally needs assistance
4=Ambulatory less than 50% of the time, nursing care needed
5=Bedridden, may require hospitalization
8=Not applicable, dead
9=Unknown or unspecified

Tumor Status: [ ]

1=No evidence of this cancer
2=Evidence of this cancer
9=Unknown, Indeterminate whether this cancer is present

C. Completing the POOH Follow-Up Record

The POOH Follow-Up Record is a one page form used for recording information on patient and tumor status following a specific cancer diagnosis. Patient follow-up information may be entered anytime after the patient's Master Record and Diagnosis Record(s) have been entered into the POOH Registry. Patients should be followed at least once a year.

A patient may have multiple Follow-Up Records. Each Follow-Up Record is linked to a specific Diagnosis Record for the patient. The following information should assist the abstractor or coder in completing a Follow-Up Record.

* * * * * * * * * * * * *

NOTE: The first seven items of information to be recorded on the Follow-Up Record should be derived from the Diagnosis Record to which the Follow-Up Record is being linked. These items include: patient ID number, patient name, morphology code, morphology, topography code, topography, and date of diagnosis.

Patient ID Number = uniquely identifies each patient in the registry. This number consists of two parts:

Part 1 = the 3 digit institution code corresponding to the institution responsible for the patient's care.

Part 2 = the 7 digit hospital chart number listed on the patient's Kansas University Medical Center hospital chart **or** the 11 digit social security number used to identify individuals in Hungary.

Patient Name = the last, first, and middle given name of the patient. When Jr. or other designators are used with a name, list this after the first name. (Example: Mark Jr. or John III)

Morphology Code = corresponds to the morphology diagnosis and should have been derived from the International Classification of Diseases for Oncology, second edition, World Health Organization, 1990.

Morphology Diagnosis = the histological name of the tumor that was diagnosed. Print in the complete name of the morphology on the line provided.

Topography Code = the three digit code that corresponds with the primary site of the cancer.

Date of Diagnosis = the date this cancer was diagnosed by a recognized medical practitioner.

* * * * * * * * * * * * *

Reporting Institution = the hospital responsible for following the patient and preparing this report. Fill in the three digit code that corresponds to the appropriate institution. At present, four institutions are listed in the POOH Tumor5.1 Registry program:

001 = Kansas University Medical Center, Kansas City, Kansas
002 = Semmelweis University Medical School, Budapest, Hungary
003 = National Institute of Neurosurgery, Budapest, Hungary
004 = Kyrgyz Institute of Oncology and Radiology, Bishkek, Kyrgyzstan

Date of this follow-up = the date of last patient contact or the patient's date of death. The date should be listed as 4 digit year, then 2 digit month, and 2 digit day. A zero must precede single-digit months and days.

Month	Day	Year
01 - January	01	Use 4 digit year
02 - February	02	9999 Year unknown
03 - March	03	
04 - April	..	
05 - May	..	
06 - June	25	
07 - July	..	
08 - August	..	
09 - September	31	
10 - October	99 Day unknown	
11 - November		
12 - December		
99 - Month unknown		

(Example: January 5, 1978 would be coded as: 19780105).

Do not record the date that follow-up information was received or requested, the date it was recorded on the abstract or the follow-up form, or the date it was entered into the computer.

Patient Vital Status = whether the patient is alive or dead. The codes to be used are:

1 = Alive
2 = Dead
9 = Unknown

Code the best available information concerning the vital status of the patient at the date of last contact or death.

If there is no follow-up information, code 9 for unknown vital status.

* * * * * * * * * * * * *

THE FOLLOWING THREE DATA ITEMS SHOULD ONLY BE CODED IF THE PATIENT IS DECEASED. IF THE PATIENT IS ALIVE OR THE VITAL STATUS IS UNKNOWN, LEAVE THESE ITEMS BLANK.

Date of Death = the date of patient death. The date should be listed as 4 digit year, then 2 digit month, and 2 digit day. A zero must precede single-digit months and days.

Month	Day	Year
01 - January	01	Use 4 digit year
02 - February	02	9999 Year unknown
03 - March	03	
04 - April	..	
05 - May	..	
06 - June	25	
07 - July	..	
08 - August	..	
09 - September	31	
10 - October	99 Day unknown	
11 - November		
12 - December		
99 - Month unknown		

(Example: January 5, 1978 would be coded as: 19780105).

Was autopsy performed? = indicates whether an autopsy was performed after the patient's death. Codes to be used here are:

1 = Yes
2 = No
9 = Unknown

Cause of Death = the underlying cause of the patient's death. When available, code the cause of death listed on the patient's death certificate or that indicated on the autopsy report or in the medical record.

Use the International Classification of Diseases (ICD-9-CM) code.

The underlying cause of death code usually has four digits. Some codes may have an optional fifth digit. Ignore the fifth digit.

If the fourth digit for the underlying cause of death is "X", "-", or absent, use 9 for the fourth digit.

When a "V" or "E" precedes the code, do not code the "V" or "E".

If the underlying cause of death is not available, do not attempt to code it; instead code 9999.

Examples:

Underlying cause of death	ICD-9	Code
Cancer of the thyroid	193	1939
Acute appendicitis with peritonitis	540.0	5400
Adenocarcinoma of stomach	151.9	1519
Fall on ice	E885	8859

Tumor Registry Code for Cause of Death = the categorical code which describes in general terms whether the cancer was due to cancer or not. Using information from the medical record, assign the appropriate one digit code from those below:

0 = Dead, Cause Apparently Other Than Cancer
1 = Dead, Cause Cancer, Apparently the Cancer Coded Here
2 = Dead, Cause Cancer Other Than This Cancer
3 = Dead, Cause Unknown

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* * * * * * * * * * * * *

<u>Patient Functional Status</u> = the patient's ability to carry on the activities of daily living at the date of last contact or death. The codes are:

1 = Normal Activity
2 = Symptomatic and ambulatory
3 = Ambulatory more than 50% of the time, occasionally needs assistance
4 = Ambulatory less than 50% of the time, nursing care needed
5 = Bedridden, may require hospitalization
8 = Not applicable, dead
9 = Unknown or unspecified

This data item changes over time. It should reflect the patient's quality of survival as specified on the date of last contact.

If the patient is dead, record 8.

<u>Tumor Status</u> = the cancer status for this primary. The codes are:

1 = No evidence of this cancer
2 = Evidence of this cancer
9 = Unknown, Indeterminate whether this cancer is present

Code the best available information concerning the cancer status of the patient at the date of last contact or death.

It should be emphasized that official death certificates do not always indicate the presence of cancer, although the registry records may demonstrate that the patient had cancer immediately before death. Code the response according to registry or physician information. Consider such items as:

How long before death was the last follow-up information obtained?

Was the last follow-up information based on an actual medical examination?

Are autopsy findings available for review?

POOH JOINT COMMISSION EVALUATION RECORD

PATIENT ID NUMBER: _____

PATIENT NAME: _____
LAST FIRST MIDDLE

MORPHOLOGY CODE: _____

MORPHOLOGY: _____

TOPOGRAPHY CODE: _____

TOPOGRAPHY: _____

DATE OF DIAGNOSIS: _____

DATE OF THIS RECORD: ____ / __ / __
Year Month Day

DATE OF DEATH (if deceased): ____ / __ / __
Year Month Day

NUMBER OF DAYS IN HOSPITAL DURING FIRST 365 DAYS AFTER THIS DIAGNOSIS: ___ DAYS

CAUSE OF EARLY DEATH:

A. This Cancer: ☐
B. Bleeding: ☐ (1=Yes 2=No 9=DK)
C. Infection: ☐
D. Other Cause: ☐

MORBIDITY DURING FIRST 365 DAYS AFTER THIS DIAGNOSIS:

A. Bleeding (Life Threatening): ☐
B. Infection (Life Threatening): ☐ (1=Yes 2=No 9=DK)
C. Other Cause (Life Threatening): ☐

DATE OF RELAPSE: ____ / __ / __
Year Month Day

D. Completing the POOH Joint Commission Evaluation Record

The POOH Joint Commission Evaluation (JCE) Record is a one page form used for recording information on patient morbidity and mortality to fulfill JCE requirements for program evaluation. The patient's JCE Record may be completed after 365 days have passed since the patient's cancer diagnosis and then entered anytime after the patient's Master Record and Diagnosis Record(s) have been entered into the POOH Registry. This record should be updated at the time of a patient's death.

A patient will have only one JCE Record for each primary cancer diagnosis. Each JCE Record is linked to a specific Diagnosis Record for the patient. The following information should assist the abstractor or coder in completing the JCE Record.

* * * * * * * * * * * *

NOTE: The first seven items of information to be recorded on the JCE Record should be derived from the Diagnosis Record to which the JCE Record is being linked. These items include: patient ID number, patient name, morphology code, morphology, topography code, topography, and date of diagnosis.

Patient ID Number = uniquely identifies each patient in the registry. This number consists of two parts:

Part 1 = the 3 digit institution code corresponding to the institution responsible for the patient's care.

Part 2 = the 7 digit hospital chart number listed on the patient's Kansas University Medical Center hospital chart or the 11 digit social security number used to identify individuals in Hungary.

Patient Name = the last, first, and middle given name of the patient. When Jr. or other designators are used with a name, list this after the first name. (Example: Mark Jr. or John III)

Morphology Code = corresponds to the morphology diagnosis and should have been derived from the International Classification of Diseases for Oncology, second edition, World Health Organization, 1990.

Morphology Diagnosis = the histological name of the tumor that was diagnosed. Print in the complete name of the morphology on the line provided.

Topography Code = the three digit code that corresponds with the primary site of the cancer.

Topography Diagnosis = the primary site of the cancer. This item identifies the site of origin of a tumor. Print in the complete topographical description on the line provided.

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Date of Diagnosis = the date this cancer was diagnosed by a recognized medical practitioner.

* * * * * * * * * * * * *

Date of this Record = the date the data were obtained from patient records and recorded on this form. The date should be listed as 4 digit year, then 2 digit month, and 2 digit day. A zero must precede single-digit months and days.

Month	Day	Year
01 - January	01	Use 4 digit year
02 - February	02	9999 Year unknown
03 - March	03	
04 - April	..	
05 - May	..	
06 - June	25	
07 - July	..	
08 - August	..	
09 - September	31	
10 - October	99 Day unknown	
11 - November		
12 - December		
99 - Month unknown		

(Example: January 5, 1978 would be coded as: 19780105).

THE FOLLOWING DATA ITEM SHOULD ONLY BE CODED IF THE PATIENT IS DECEASED. IF THE PATIENT IS ALIVE OR THE VITAL STATUS IS UNKNOWN, LEAVE THIS ITEM BLANK.

Date of Death (if deceased) = the date of patient death. The date should be listed as 4 digit year, then 2 digit month, and 2 digit day. A zero must precede single-digit months and days.

Month	Day	Year
01 - January	01	Use 4 digit year
02 - February	02	9999 Year unknown
03 - March	03	
04 - April	..	
05 - May	..	
06 - June	25	
07 - July	..	
08 - August	..	
09 - September	31	
10 - October	99 Day unknown	
11 - November		
12 - December		
99 - Month unknown		

(Example: January 5, 1978 would be coded as: 19780105).

Number of Days in Hospital during First 365 Days after this Diagnosis = the total number of days the patient spent hospitalized as an inpatient during the first year after the cancer diagnosis. This information should be obtained by reviewing the patient's complete hospital chart and other available records. Days admitted for the cancer, infections, chemotherapy or other treatments, complications, and any other reason should be included in this count.

THE FOLLOWING DATA ITEM SHOULD ONLY BE CODED IF THE PATIENT IS DECEASED. IF THE PATIENT IS ALIVE OR THE VITAL STATUS IS UNKNOWN, LEAVE THIS ITEM BLANK.

Cause of Early Death = the underlying cause of the patient's death. Refer to the Follow-Up Record(s) on this patient, the patient's hospital chart, death certificate and/or autopsy report to determine the cause of the patient's death.

Indicate using 1=Yes, 2=No, or 3=DK (Don't Know) as to whether the cause or causes included: this cancer, bleeding, infection, or some other cause.

Morbidity During First 365 Days after this Diagnosis = **life threatening** sequelae that occurred within the first year after this cancer was diagnosed. The following criteria must be met in order to consider any category a 1=Yes:

Infection = <500 absolute neutrophil count, evidence of positive blood cultures, OR evidence of localization (pneumonia, meningitis, cellulitis, etc.).

Fever = temperature >38 degrees Celsius lasting for more than 5 days.

Bleeding = sudden decrease in hemoglobin and shock, >25% drop in hemoglobin at any one time, OR >2 grams drop in hemoglobin per day lasting 3 days or more.

Code each category as 1=Yes, if the above criteria are met; or 2=No or 9=DK (Don't Know).

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Date of Relapse = the date the cancer first came out of remission or recurred as determined by: bone marrow biopsy for leukemias, first metastasis (for all cancers except leukemias), or physician diagnosis. The date should be listed as 4 digit year, then 2 digit month, and 2 digit day. A zero must precede single-digit months and days.

Month	Day	Year
01 - January	01	Use 4 digit year
02 - February	02	9999 Year unknown
03 - March	03	
04 - April	..	
05 - May	..	
06 - June	25	
07 - July	..	
08 - August	..	
09 - September	31	
10 - October	99 Day unknown	
11 - November		
12 - December		
99 - Month unknown		

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APPENDIX A

STATE ABBREVIATION CODES LIST

Alabama	AL	Missouri	MO
Alaska	AK	Montana	MT
Arizona	AZ	Nebraska	NE
Arkansas	AR	Nevada	NV
California	CA	New Hampshire	NH
Colorado	CO	New Jersey	NJ
Connecticut	CT	New Mexico	NM
Delaware	DE	New York	NY
Florida	FL	North Carolina	NC
Georgia	GA	North Dakota	ND
Hawaii	HI	Ohio	OH
Idaho	ID	Oklahoma	OK
Illinois	IL	Oregon	OR
Indiana	IN	Pennsylvania	PA
Iowa	IA	Rhode Island	RI
Kansas	KS	South Carolina	SC
Kentucky	KY	South Dakota	SD
Louisiana	LA	Tennessee	TN
Maine	ME	Texas	TX
Maryland	MD	Utah	UT
Massachusetts	MA	Vermont	VT
Michigan	MI	Virginia	VA
Minnesota	MN	Washington	WA
Mississippi	MS	West Virginia	WV
		Wisconsin	WI
		Wyoming	WY

APPENDIX B

COUNTRY GEOCODES LIST

COUNTRY	CODE
Afghanistan	110
Albania	120
Algeria	125
American Samoa	060
Angola	141
Antarctica	143
Antigua and Barbuda	149
Argentina	150
Armenia	135
Aruba	100
Ashmore and Cartier	155
Australia	160
Austria	165
Azerbaijan	115
Bahamas	180
Bahrain	181
Bangladesh	182
Barbados	184
Belgium	190
Belize	227
Benin	311
Bermuda	195
Bolivia	205
Bosnia-Herzegovina	185
Botswana	210
Brazil	220
British Virgin Islands	231
Brunei	232
Bulgaria	245
Burkina	927
Burma	250
Burundi	252
Byelarus	211
Cambodia	255
Cameroon	257
Canada	260
Cape Verde	264
Cayman Islands	268
Central African Republic	269
Chad	273
Chile	275
China	280
Colombia	285
Comoros	286
Congo	290
Cook Islands	293
Costa Rica	295
Croatia	440
Cuba	300
Cyprus	305

COUNTRY GEOCODES LIST

COUNTRY	CODE
Czechoslovakia	310
Denmark	315
Djibouti	317
Dominica	318
Dominican Republic	320
Ecuador	325
Egypt	922
El Salvador	330
Equatorial Guinea	332
Estonia	331
Ethiopia	335
Falkland Island	337
Fed States Micronesi	063
Fiji	338
Finland	340
France	350
French Guiana	355
French Polynesia	367
Gabon	388
Gambia	389
Gaza Strip	393
Georgia	390
Germany	394
Ghana	396
Gibraltar	397
Greece	400
Greenland	405
Grenada	406
Guadeloupe	407
Guam	066
Guatemala	415
Guinea	417
Guinea-Bissau	737
Guyana	418
Haiti	420
Honduras	430
Hong Kong	435
Hungary	445
Iceland	450
India	455
Indonesia	458
Iran	460
Iraq	465
Ireland	470
Israel	475
Italy	480
Ivory Coast	485
Jamaica	487
Japan	490
Jordan	500
Kazakhstan	525

COUNTRY GEOCODES LIST

COUNTRY	CODE
Kenya	505
Kiribati	398
Korea, Dem Peoples Rep	514
Korea, Republic of	515
Kuwait	520
Kyrgyzstan	510
Laos	530
Latavia	541
Lebanon	540
Lesotho	543
Liberia	545
Libya	550
Liechtenstein	553
Lithuania	542
Luxembourg	570
Macau	573
Madagascar	575
Malawi	577
Malaysia	580
Maldives	583
Mali	585
Malta	590
Man, Isle of	588
Marshall Islands	073
Martinique	591
Mauritania	592
Mauritius	593
Mexico	595
Moldova	576
Monaco	607
Mongolia	608
Montserrat	609
Morocco	610
Mozambique	615
Namibia	821
Nauru	621
Nepal	625
Netherlands	630
Netherlands Antilles	640
New Caledonia	645
New Zealand	660
Nicaragua	665
Niger	667
Nigeria	670
Northern Mariana Is	069
Norway	685
Oman	616
Pakistan	700
Panama	710
Papua New Guinea	712
Paraguay	715

COUNTRY GEOCODES LIST

COUNTRY	CODE
Peru	720
Philippines	725
Poland	730
Portugal	735
Puerto Rico	072
Qatar	747
Romania	755
Russia	825
Rwanda	758
Saudi Arabia	785
Senegal	787
Seychelles	788
Sierra Leone	790
Singapore	795
Slovenia	789
Solomon Islands	229
Somalia	800
South Africa	801
Spain	830
Sri Lanka	272
St. Helena	765
St. Kitts and Nevis	763
St. Lucia	770
St. Vincent/Grenadin	775
Sudan	835
Suriname	840
Swaziland	847
Sweden	850
Switzerland	855
Syria	858
Taiwan	281
Tajikistan	784
Tanzania, United Rep	865
Thailand	875
Togo	883
Tokelau	884
Tonga	886
Trinidad and Tobago	887
Tunisia	890
Turkey	905
Turkmenistan	909
Turks and Caicos Island	906
Tuvalu	908
Uganda	910
Ukarine	928
United Arab Emirates	888
United Kingdom	925
United States	926
Uruguay	930
Uzbekistan	931
Vatican City	934

COUNTRY GEOCODES LIST

COUNTRY	CODE
Venezuela	940
Vietnam	945
Virgin Islands	078
Western Sahara	831
Western Samoa	963
Yemen	965
Yugoslavia	970
Zaire	291
Zimbabwe	818

DATA ENTRY INSTRUCTION MANUAL
(For use with the POOH Tumor 6.10 Registry Program)

Manual by: Cathy D. Boysen, University of Kansas Medical Center

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HOW TO USE THIS MANUAL

This manual has been designed for use by data entry personnel. It provides instructions for data entry (key strokes are shown in **bold**) along with screens that come up at each step of the data entry process.

Data entry personnel are responsible for data entry only. Edit of data screens and dictionaries should be performed by Data Managers in order to provide consistency between the partner hospitals.

Suggestions for modification of this manual or the POOH Registry Program are welcomed and should be conveyed to the Data Managers at the respective hospitals.

GENERAL DATA ENTRY INSTRUCTIONS

1- Use **Caps Lock** when entering text.

2- Use [←], [**Backspace**] or [**Delete**] to make corrections when entering data.

3- Use [↑] to backtrack, when necessary.

4- When fields are automatically filled with correct information by the computer program, hit [**Enter**] to move onto the next empty field and continue data entry.

5- Hit [**Ctrl-Enter**] to enter a screen of data and move to the next screen.

6- Be aware that the screen will go dark after a few minutes if no use is made of the POOH program. The screen last viewed can be brought up again by hitting [**Enter**].

7- Ignore blue areas on the data entry screens. **Do not modify items in these blue fields.**

LOADING AND BOOTING TUMOR5.1

To copy tumor5.1 to your hard drive:

C:\>

C:\>**md tumor5.1 [ENTER]**

C:\>

C:\>**cd\tumor5.1 [ENTER]**

C:TUMOR5.0>

Put diskette with tumor5.1 program in drive A

C:\TUMOR5.1>**copy A:*.* C: [ENTER]**

Once the TUMOR5.1 program is on your hard drive, you may need to increase the number of files that may be open at one time in order for the program to run.

Refer to your operating system manual to determine how to do this. Increase the files=55.

To boot up the program:

C:\>

C:\>**cd\tumor5.1 [ENTER]**

C:\TUMOR5.1>**tumor [ENTER]**

37

TUMOR PROGRAM SUFFIXES:

*.EXE
*.HLP
*.DAT
*.K01
*.K02
*.K03
*.K04
*.K05
*.DMP
*.APP
*.SCN
*.MDL
*.CLA

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ENTERING PATIENT DATA

I. Creating a patient master record

Creating a patient master record is the first step required in the process of entering patient data into the POOH registry.

Boot up the program:

C:\>

C:\>**cd\tumor5.1 [ENTER]**

C:\TUMOR5.1>**tumor [ENTER]**

```
XXXXXXXXXX      XXXXXX        XXXXXX      XX       XX
XX      XX  XX      XX    XX      XX    XX       XX
XX      XX  XX       XX   XX       XX   XX       XX
XXXXXXXXXX  XX       XX   XX       XX   XXXXXXXXXX
XX          XX       XX   XX       XX   XX       XX
XX           XX     XX    XX     XX     XX       XX
XX             XXXXXX       XXXXXX      XX       XX

   P E D I A T R I C   O N C O L O G Y   O U T R E A C H

                      H U N G A R Y

                    VERSION  5.10

          KANSAS UNIVERSITY MEDICAL CENTER
        Director: Frederick F. Holmes, M.D.
                                                      0
```

[ENTER]

```
                Data Base Options

      MAY REQUIRE IDENTIFICATION OF PATIENT

          Patient Related Data Input
            Select Printed Reports
              Erase Patient Files

      REQUIRES NO IDENTIFICATION OF PATIENT
          Data File Editing Procedures
        Reference File Editing Procedures
      Create Disease Specific Sub-Fields
       Rectify Temporary Diagnosis Codes
            Process Survival Curves

Make Selection or ESC to Return; F1 for help
```

[ENTER]

90

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
  Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data
Enter Treatment Data

View Current Patient Summary
Make Selection or ESC; F1 for Help
```

[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
  Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edi                                  Data
   IDENTIFY CURRENT PATIENT
    1 = NEW PATIENT INPUT

    2 = ESTABLISHED PATIENT
Ma                                   lp
              0
    0 = ABORT STEP
```

[1]

91

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edi                                   Data
IDENTIFY CURRENT PATIENT
 1 = NEW PATIENT INPUT

 2 = ESTABLISHED PATIENT
Ma                                    lp
          1
 0 = ABORT STEP
```

[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Cu
                ENTER NEW PATIENT
Edit/View/Ente     ID NUMBER
Edit/View/Enter D FIRST THREE DIGITS
Edit/View/Ente  MUST BE DIGITS OF
Edit/View/Enter J INSTITUTION CODE
                     NUMBER

View Current
Make Selection o
```

KEY IN PATIENT ID NUMBER from patient's MASTER RECORD (paper abstract)

92

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Cu
Edit/View/Ente
Edit/View/Enter D
Edit/View/Ente
Edit/View/Enter J
View Current
Make Selection o
```

ENTER NEW PATIENT ID NUMBER
FIRST THREE DIGITS MUST BE DIGITS OF INSTITUTION CODE NUMBER
00218812046789

[ENTER]

```
Data Base Options
REPORTING INSTITUTIONS

NAME OF INSTITUTION                INSTITUTION CODE
Kansas University Medical Center   001
Semmelweis Univ. Medical School    002
National Inst. of Neurosurgery     003

For Patient: 00218812046789                ESC to Continue
```

[↓] to institution listed on patient's MASTER RECORD (paper abstract)
[ENTER]

93

```
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

Patient Related Data Input

Options for Patient Data Input

Id        REPORTING          nt
          INSTITUTION CODE
Edit/     IS                 gnosis
Edit/Vie  002                ific Data
Edit/     0                   Data
Edit/Vie                     sion Data

View Current Patient Summary

Make Selection or ESC; F1 for Help
```

[ENTER]

```
Data Input Form for Master     1ST THREE DIGITS  OF PATIENT ID NO
Record will be Added           MUST BE  ROOT INSTITUTION CODE NUMBER
Patient ID Number            PTID     :00218812046789        RACE CODES
Patient Last Name            PLNAME   :                      01 = White
Patient First Name           PFNAME   :                      02 = Black
Patient Middle Name          PMNAME   :                      03 = Asian/Orient
Mother Last Name (Maiden)    MLNAME   :                      04 = Hispanic
Mother First Name            MFNAME   :                      05 = Amerind,Esk
Mother Middle Name           MMNAME   :                      06 = Gypsy
Date of Birth                DOB      :         yyyymmdd     98 = Other
Date of First Diagnosis      DOE      :         yyyymmdd     99 = Unknown
Race/Ethnicity Code          RACE ETH:
Sex (M=1;2=F;3=other;9=Unk)SEX        :
Street Address               STREET   :
City Address                 CITY     :
State of Residence           STATE    :
Postal Code                  ZIP      :00000-0000     PRESS F1 FOR HELP
Country Code                 NATION   :000            PRESS F5 FOR SUMMARY
Father's Name:Last:                     First:                Middle Init:
Place of Birth--  City:                              State:     Nation:
Postal Code of Birth         BZIP     :00000-0000
```

[ENTER]

94

```
        Data Input Form for Master     1ST THREE DIGITS  OF PATIENT ID NO
           Record will be Added        MUST BE  ROOT INSTITUTION CODE NUMBER
Patient ID Number            PTID     :00218812046789        RACE CODES
Patient Last Name            PLNAME   :PATIENT               01 = White
Patient First Name           PFNAME   :TEST                  02 = Black
Patient Middle Name          PMNAME   :A                     03 = Asian/Orient
Mother Last Name (Maiden)    MLNAME   :SMITH                 04 = Hispanic
Mother First Name            MFNAME   :JUDY                  05 = Amerind,Esk
Mother Middle Name           MMNAME   :S                     06 = Gypsy
Date of Birth                DOB      :19881204 yyyymmdd     98 = Other
Date of First Diagnosis      DOE      :19920401 yyyymmdd     99 = Unknown
Race/Ethnicity Code          RACE ETH:06
Sex (M=1;2=F;3=other;9=Unk)SEX        :2
Street Address               STREET   :1234 S.W. VISTA DRIVE
City Address                 CITY     :BUDAPEST
State of Residence           STATE    :
Postal Code                  ZIP      :00000-1234     PRESS F1 FOR HELP
Country Code                 NATION   :445            PRESS F5 FOR SUMMARY
Father's Name:Last: PATIENT            First: HENRY        Middle Init: T
Place of Birth--  City: BUDAPEST                     State:     Nation: 445
Postal Code of Birth         BZIP     :00000-6789
```

KEY IN PATIENT DATA from the patient's MASTER RECORD (paper abstract).
[ENTER] or ↓ after keying each data item.
[Print Screen] after entering last data item.
[CTRL-ENTER] to input data and go on to the next screen.

```
                    Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
  Patient Related Data Input
                 Options for Patient Data Input
                    Identify Current Patient

              Edit/View/Enter Tumor Diagnosis
           Edit/View/Enter Disease Specific Data
              Edit/View/Enter Follow-Up Data
           Edit/View/Enter Joint Commission Data

                 View Current Patient Summary
              Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

GO TO PAGE 17 to enter this patient's diagnostic information.
-OR-
[ESC] to return to DATA BASE OPTIONS menu.

II. Entering diagnostic information

The patient's cancer diagnosis (morphology and topography) may be entered anytime after the patient's Master Record has been entered into the POOH Registry. A patient may have multiple Diagnosis Records, but will only have one Master Record on file. The patient's Master Record and Diagnosis Records are automatically linked by the POOH Registy program using the Patient ID Number, which is unique for each patient.

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
    Patient Related Data Input
      Select Printed Reports
        Erase Patient Files

REQUIRES NO IDENTIFICATION OF PATIENT
    Data File Editing Procedures
  Reference File Editing Procedures
 Create Disease Specific Sub-Fields
  Rectify Temporary Diagnosis Codes

Make Selection or ESC to Return; F1 for help
```

[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
    Patient Related Data Input

Options for Patient Data Input
Identify Current Patient

   Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
   Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

View Current Patient Summary
Make Selection or ESC; F1 for Help
```

GO TO PAGE 17 if the patient for whom you are creating a Diagnosis Record has already been identified and is displayed in the red line at the bottom of your computer screen.

-OR-

[ENTER] if the patient has not been identified.

96

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edi                                  Data
Ma                                   lp

IDENTIFY CURRENT PATIENT
 1 = NEW PATIENT INPUT

 2 = ESTABLISHED PATIENT

          0
 0 = ABORT STEP
```

[2]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edi                                  Data
Ma                                   lp

IDENTIFY CURRENT PATIENT
 1 = NEW PATIENT INPUT

 2 = ESTABLISHED PATIENT

          2
 0 = ABORT STEP
```

[ENTER]

97

* * * OPTION 1 TO IDENTIFY THE PATIENT * * * *
(USE PATIENT ID NUMBER)

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Pa
Identify Cu
Edit/View/Ente
Edit/View/Enter D
Edit/View/Ente
Edit/View/Enter J
View Current
Make Selection o

SELECT SOURCE FOR ID NUMBER
 FOR ESTABLISHED PATIENT

 1 = ENTER NUMBER FROM
     KEYBOARD
 2 = SEARCH FOR NUMBER BY
       LAST NAME
 3 = SEARCH ENTIRE MASTER
         LIST

          0
```

[1]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Pa
Identify Cu
Edit/View/Ente
Edit/View/Enter D
Edit/View/Ente
Edit/View/Enter J
View Current
Make Selection o

SELECT SOURCE FOR ID NUMBER
 FOR ESTABLISHED PATIENT

 1 = ENTER NUMBER FROM
     KEYBOARD
 2 = SEARCH FOR NUMBER BY
       LAST NAME
 3 = SEARCH ENTIRE MASTER
         LIST

          1
```

[ENTER]

98

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
  Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

   Edit/View/Enter Tumor Diagno   ENTER ID NUMBER
Edit/View/Enter Disease Specifi   FOR ESTABLISHED
   Edit/View/Enter Follow-Up Da       PATIENT
Edit/View/Enter Joint Commissio

    View Current Patient Summar
Make Selection or ESC; F1 for Help
```

KEY IN PATIENT ID NUMBER from patient's MASTER RECORD (paper abstract).

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
  Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

   Edit/View/Enter Tumor Diagno   ENTER ID NUMBER
Edit/View/Enter Disease Specifi   FOR ESTABLISHED
   Edit/View/Enter Follow-Up Da       PATIENT
Edit/View/Enter Joint Commissio

                                  00218812046789
    View Current Patient Summar
Make Selection or ESC; F1 for Help
```

[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
  Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

   Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
   Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

    View Current Patient Summary
Make Selection or ESC; F1 for Help
```

GO TO PAGE 17

* * * OPTION 2 TO IDENTIFY THE PATIENT * * * *
(USE PATIENT LAST NAME)

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Pa
Identify Cu
Edit/View/Ente
Edit/View/Enter D
Edit/View/Ente
Edit/View/Enter J
View Current
Make Selection o

SELECT SOURCE FOR ID NUMBER
FOR ESTABLISHED PATIENT

1 = ENTER NUMBER FROM
    KEYBOARD
2 = SEARCH FOR NUMBER BY
    LAST NAME
3 = SEARCH ENTIRE MASTER
    LIST

0
```

[2]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Pa
Identify Cu
Edit/View/Ente
Edit/View/Enter D
Edit/View/Ente
Edit/View/Enter J
View Current
Make Selection o

SELECT SOURCE FOR ID NUMBER
FOR ESTABLISHED PATIENT

1 = ENTER NUMBER FROM
    KEYBOARD
2 = SEARCH FOR NUMBER BY
    LAST NAME
3 = SEARCH ENTIRE MASTER
    LIST

2
```

[ENTER]

100

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
  Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

ENTER LAST NAME FOR WHICH TO SEARCH
```

KEY IN PATIENT LAST NAME from patient's MASTER RECORD (paper abstract).

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
  Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

ENTER LAST NAME FOR WHICH TO SEARCH
    PATIENT
```

[ENTER]

101

```
PATIENT MASTER LIST

PT ID NO  LAST NAME          FIRST NAME  MIDDLE NAME
00133333333333 PATIENT        CHARLES        P
00218812046789 PATIENT        TEST           A

For Patient:
To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape
```

[↓] to patient to be selected.
[ENTER]

```
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

Patient Related Data Input

Options for Patient Data Input

Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

View Current Patient Summary

Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

GO TO PAGE 17

* * * OPTION 3 TO IDENTIFY THE PATIENT * * * *
(SEARCH ENTIRE LIST OF PATIENTS IN THE REGISTRY)

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Pa
Identify Cu
Edit/View/Ente
Edit/View/Enter D
Edit/View/Ente
Edit/View/Enter J
View Current
Make Selection o

SELECT SOURCE FOR ID NUMBER
 FOR ESTABLISHED PATIENT

 1 = ENTER NUMBER FROM
     KEYBOARD
 2 = SEARCH FOR NUMBER BY
       LAST NAME
 3 = SEARCH ENTIRE MASTER
       LIST

       0
```

[3]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Pa
Identify Cu
Edit/View/Ente
Edit/View/Enter D
Edit/View/Ente
Edit/View/Enter J
View Current
Make Selection o

SELECT SOURCE FOR ID NUMBER
 FOR ESTABLISHED PATIENT

 1 = ENTER NUMBER FROM
     KEYBOARD
 2 = SEARCH FOR NUMBER BY
       LAST NAME
 3 = SEARCH ENTIRE MASTER
       LIST

       3
```

[ENTER]

PATIENT MASTER LIST

PT ID NO	LAST NAME	FIRST NAME	MIDDLE NAME
0019097531	ANNA	BEN	
001809876	BLACK	CHERRY	PIT
001920304	BLOSSOM	CHERRY	PIT
001796543	GERM	WHEAT	YUK
001123456789999	GRANATE	PAM	
001854567	HEAD	TINY	
002666666666	JONES	TERRY	R
001777777777	JONES	PETE	R
001888888888	JONES	MARTHA	P
00133333333333	PATIENT	CHARLES	P
00218812046789	PATIENT	TEST	A
002555555555	PERSON	PETER	S
0018012345	PRUNE	PURPLE	PITTED
0024444444444	SAMPLE	SUE	T

For Patient: 00218812046789 PATIENT,TEST
To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape

[↓] to patient to be selected.
[ENTER]

Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

Patient Related Data Input

Options for Patient Data Input

Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

View Current Patient Summary

Make Selection or ESC; F1 for Help

00218812046789 PATIENT,TEST

GO TO NEXT PAGE

104

* * **START HERE AFTER YOU HAVE IDENTIFIED THE PATIENT FOR WHOM YOU WANT TO INPUT DIAGNOSTIC INFORMATION** * *

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

[↓] to Edit/View/Enter Tumor Diagnosis
[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
SELECT SOURCE FOR CURRENT PATIENT
DIAGNOSIS RECORD
1 = CREATE NEW DIAGNOSIS RECORD
2 = UPDATE EXISTING DIAGNOSIS
RECORD

0
Press F1 for Help
```

00218812046789 PATIENT,TEST

[1]

105

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient
Edit/View/Enter Tumor Diagnosis
SELECT SOURCE FOR CURRENT PATIENT
DIAGNOSIS RECORD
1 = CREATE NEW DIAGNOSIS RECORD
2 = UPDATE EXISTING DIAGNOSIS
RECORD
1
Press F1 for Help
```

00218812046789 PATIENT,TEST

[ENTER]

```
DISEASE SPECIFIC CATEGORIES
TOPOGRAPHIC DIAGNOSIS          ICD CODE
LEUKEMIAS
NON-HODGINS LYMPHOMA
HODGKIN'S DISEASE
WILM'S TUMOR
NEUROBLASTOMA
BONE AND JOINT TUMORS
EWING'S SARCOMA
RHABDOMYSARCOMA
CENTRAL NERVOUS
OTHER RARE TUMORS
RETINOBLASTOMA
For Patient: 00218812046789 PATIENT,TEST
To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape
```

00218812046789 PATIENT,TEST

[↓] to Disease Specific Category listed on patient's DIAGNOSIS RECORD (paper abstract)
[ENTER]

SELECT INSTITUTION CODE FROM LIST

REPORTING INSTITUTIONS

NAME OF INSTITUTION	INSTITUTION CODE
Kansas University Medical Center	001
Semmelweis Univ. Medical School	002
National Inst. of Neurosurgery	003

For Patient: 00218812046789 PATIENT,TEST
To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape

00218812046789 PATIENT,TEST

[↓] to Institution Reporting this Diagnosis listed on the patient's DIAGNOSIS RECORD (paper abstract)
[ENTER]

SELECT INSTITUTION CODE FROM LIST
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

Patient Related Data Input

Optio | Input

Id | nt
Edit/ | gnosis
Edit/Vie | ific Data
Edit/ | Data
Edit/Vie | sion Data

REPORTING
INSTITUTION CODE
IS
002
0

View Current Patient Summary

Make Selection or ESC; F1 for Help

00218812046789 PATIENT,TEST

[ENTER]

107

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Commission Data

SOURCE OF MOPHOLOGIC DIAGNOSIS

0 = KEYBOARD; 1 = DICTIONARY

Press enter to continue
0

ent Summary
C; F1 for Help

00218812046789  PATIENT,TEST                MAKE MORPHOLOGIC DIAGNOSIS
```

[1]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Commission Data

SOURCE OF MOPHOLOGIC DIAGNOSIS

0 = KEYBOARD; 1 = DICTIONARY

Press enter to continue
1

ent Summary
C; F1 for Help

00218812046789  PATIENT,TEST                MAKE MORPHOLOGIC DIAGNOSIS
```

[ENTER]

108

IF NO SELECTION IN DICTIONARY,THEN ESCAPE AND OPTION FOR KEYBOARD INPUT APPEARS

```
                    MORPHOLOGY DIAGNOSIS

   MORPHOLOGY CODE  MORPHOLOGY DIAGNOSIS
   OSTEOSARCOMA                    9180/3
   CHONDROSARCOMA                  9220/3

 For Patient: 00218812046789  PATIENT,TEST
 To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape
```

00218812046789 PATIENT,TEST MAKE MORPHOLOGIC DIAGNOSIS

[↓] to Morphology Diagnosis and Code listed on patient's DIAGNOSIS RECORD (paper abstract)
[ENTER]

-OR-

GO TO PAGE 25 if the patient's morphology diagnosis is not listed in the dictionary.

```
                    Data Base Options
          MAY REQUIRE IDENTIFICATION OF PATIENT
             | Patient Related Data Input |
 Optio  ENTER OFFICIAL   Input
        DATE OF THIS
        PATIENT DIAGNOSIS
        RECORD
   Id                    nt
   Edit/  00000000       gnosis
Edit/Vie  yyyymmdd       ific Data
   Edit/                  Data
Edit/View/Enter Joint Commission Data

          View Current Patient Summary
          Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST MAKE MORPHOLOGIC DIAGNOSIS

KEY DATE OF DIAGNOSIS listed on the patient's DIAGNOSIS RECORD (paper abstract)

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Optio   ENTER OFFICIAL   Input
        DATE OF THIS
     Id PATIENT DIAGNOSIS nt
        RECORD
   Edit/   19920401      gnosis
Edit/Vie   yyyymmdd      ific Data
   Edit/                 Data
Edit/View/Enter Joint Commission Data

View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST MAKE MORPHOLOGIC DIAGNOSIS

[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
                Commission Data

ENTER: 0 = SKIP TOPOGRAPHY
                                ent Summary
       1 = MAKE TOPOGRAPHY
                                C; F1 for Help
Press enter to continue
        1
```

00218812046789 PATIENT,TEST OSTEOSARCOMA

[1]
[ENTER]

110

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
SOURCE OF TOPOGRAPHIC DIAGNOSIS
0 = TOPOGRAPHIC DIAGNOSIS WAS
    ALREADY ENTERED. RETURN.
1 = ENTER TOPOGRAPHY FROM KEYBOARD
2 = ENTER TOPOGRAPHY FROM DICTIONARY
1
```

00218812046789 PATIENT,TEST OSTEOSARCOMA

[2]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
SOURCE OF TOPOGRAPHIC DIAGNOSIS
0 = TOPOGRAPHIC DIAGNOSIS WAS
    ALREADY ENTERED. RETURN.
1 = ENTER TOPOGRAPHY FROM KEYBOARD
2 = ENTER TOPOGRAPHY FROM DICTIONARY
2
```

00218812046789 PATIENT,TEST OSTEOSARCOMA

[ENTER]

IF SELECTION NOT MADE THEN ESCAPE. OPTION TO MAKE A KEYBOARD ENTRY THEN APPEARS

```
TOPOGRAPHIC DIAGNOSIS

TOPOGRAPHIC CODE  SITES DIAGNOSIS
LONG BONES OF UPPER LIMB,SCAPULA 40.0
SHORT BONES OF UPPER LIMB        40.1
LONG BONES OF LOWER LIMB         40.2
SHORT BONES OF LOWER LIMB        40.3
OVERLAPPING LESIONS, LOWER LIMB  40.8
BONES OF LIMBS, NOS              40.9
BONES OF SKULL AND FACE          41.0
MANDIBLE                         41.1
VERTEBRAL COLUMN                 41.2
RIBS, STERNUM, CLAVICLE          41.3
PELVIC BONES, SACRUM, COCCYX     41.4
OVERLAPPING LESIONS OF SKELETON  41.8
BONE, NOS                        41.9

For Patient: 00218812046789  PATIENT,TEST
To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape

00218812046789  PATIENT,TEST              OSTEOSARCOMA
```

[↓] to Topography Diagnosis and Code listed on patient's DIAGNOSIS RECORD (paper abstract).
[ENTER]

-OR-

GO TO PAGE 27 if the patient's topography diagnosis is not listed in the dictionary.

```
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

Patient Related Data Input

Options for Patient Data Input

Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

View Current Patient Summary

Make Selection or ESC; F1 for Help

00218812046789  PATIENT,TEST              OSTEOSARCOMA
```

[ESC] X 2 to exit Registry program, if desired.

112

* * * * WHAT TO DO IF. . . * * * *
THE PATIENT'S MORPHOLOGY DIAGNOSIS IS NOT LISTED IN THE DICTIONARY:

IF NO SELECTION IN DICTIONARY,THEN ESCAPE AND OPTION FOR KEYBOARD INPUT APPEARS

```
                    MORPHOLOGY DIAGNOSIS

  MORPHOLOGY CODE  MORPHOLOGY DIAGNOSIS
  OSTEOSARCOMA                    9180/3
  CHONDROSARCOMA                  9220/3

  For Patient: 00218812046789  PATIENT,TEST
  To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape
```

00218812046789 PATIENT,TEST MAKE MORPHOLOGIC DIAGNOSIS

[ESC]

```
                    Data Base Options
          MAY REQUIRE IDENTIFICATION OF PATIENT
              Patient Related Data Input
          Options for Patient Data Input
        NO MORPHOLOGIC DIAGNOSIS WAS SELECTED
                FROM THE DICTIONARY
             PLEASE INDICATE YOUR CHOICE

         0 = RETURN TO MENU
         1 = ENTER DIAGNOSIS FROM KEYBOARD

                        0
```

00218812046789 PATIENT,TEST MAKE MORPHOLOGIC DIAGNOSIS

[0]
[ENTER]

113

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
NO MORPHOLOGIC DIAGNOSIS                ata Input
CANNOT PROCEED;RETURN TO MENU           atient
Press enter to continue                  Diagnosis
1                                       Specific Data
                                        w-Up Data
                                        mmission Data
View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST MAKE MORPHOLOGIC DIAGNOSIS

[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient
Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data
View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST MAKE MORPHOLOGIC DIAGNOSIS

PUT A NOTE ON THE PATIENT'S DIAGNOSIS RECORD TO INDICATE IT HAS NOT BEEN ENTERED AND BRING IT TO THE ATTENTION OF YOUR DATA MANAGER SO THAT THE PROBLEM WITH THE MORPHOLOGY DICTIONARY MAY BE RESOLVED AND THE DIAGNOSIS RECORD MAY BE ENTERED.

* * * * WHAT TO DO IF. . . * * * *
THE PATIENT'S TOPOGRAPHY DIAGNOSIS IS NOT LISTED IN THE DICTIONARY:

IF SELECTION NOT MADE THEN ESCAPE. OPTION TO MAKE A KEYBOARD ENTRY THEN APPEARS

```
                    TOPOGRAPHIC DIAGNOSIS

   TOPOGRAPHIC CODE  SITES DIAGNOSIS
   LONG BONES OF UPPER LIMB,SCAPULA 40.0
   SHORT BONES OF UPPER LIMB        40.1
   LONG BONES OF LOWER LIMB         40.2
   SHORT BONES OF LOWER LIMB        40.3
   OVERLAPPING LESIONS, LOWER LIMB  40.8
   BONES OF LIMBS, NOS              40.9
   BONES OF SKULL AND FACE          41.0
   MANDIBLE                         41.1
   VERTEBRAL COLUMN                 41.2
   RIBS, STERNUM, CLAVICLE          41.3
   PELVIC BONES, SACRUM, COCCYX     41.4
   OVERLAPPING LESIONS OF SKELETON  41.8
   BONE, NOS                        41.9

 For Patient: 00218812046789  PATIENT,TEST
 To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape
```

00218812046789 PATIENT,TEST OSTEOSARCOMA

[ESC]

```
                    Data Base Options

          MAY REQUIRE IDENTIFICATION OF PATIENT

              Patient Related Data Input

                Options for Patient Data Input

          NO TOPOGRAPHIC DIAGNOSIS WAS SELECTED
                  FROM THE DICTIONARY
               PLEASE INDICATE YOUR CHOICE

           0 = RETURN TO MENU
           1 = ENTER DIAGNOSIS FROM KEYBOARD

                          0
```

00218812046789 PATIENT,TEST OSTEOSARCOMA

[0]
[ENTER]

115

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
ata Input
atient
Press enter to continue
2
Diagnosis
Specific Data
w-Up Data
mmission Data
View Current Patient Summary
Make Selection or ESC; F1 for Help
```

[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient
Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data
View Current Patient Summary
Make Selection or ESC; F1 for Help
```

```
00218812046789  PATIENT,TEST              OSTEOSARCOMA
```

PUT A NOTE ON THE PATIENT'S DIAGNOSIS RECORD TO INDICATE IT HAS NOT BEEN ENTERED AND BRING IT TO THE ATTENTION OF YOUR DATA MANAGER SO THAT THE PROBLEM WITH THE TOPOGRAPHY DICTIONARY MAY BE RESOLVED AND THE DIAGNOSIS RECORD MAY BE ENTERED.

III. Entering follow-up information

Follow-up information on a patient may be entered anytime after the patient's Master Record and Diagnosis Record(s) have been entered into the POOH Registry. A patient may have multiple Follow-up Records. Each Follow-up Record is linked to a specific Diagnosis Record for the patient and reflects information about the status of the tumor and the patient since the time of the cancer diagnosis.

```
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

    Patient Related Data Input
      Select Printed Reports
        Erase Patient Files

REQUIRES NO IDENTIFICATION OF PATIENT
    Data File Editing Procedures
  Reference File Editing Procedures
 Create Disease Specific Sub-Fields
  Rectify Temporary Diagnosis Codes

Make Selection or ESC to Return; F1 for help
```

[ENTER]

```
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

    Patient Related Data Input

Options for Patient Data Input

Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

View Current Patient Summary

Make Selection or ESC; F1 for Help
```

The patient for whom you are entering follow-up information should be displayed in the red line at the bottom of your computer screen. If no patient has been identified, refer to pages 8-16 of this manual for information on identifying the patient. After identifying the patient, **GO TO PAGE 30**.

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```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
  Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

[↓] to Edit/View/Enter Follow-Up Data
[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
PROCESS FOLLOW-UP RECORD
Correct patient master record must
be current. Record must be linked
to PATIENT/DIAGNOSIS record. This
must be selected as follows:
INSTRUCTIONS FOR SELECTING
PATIENT DIAGNOSIS RECORD
Scroll to Patient Diagnosis Record
If Not Found then Strike ESC
If Found then Strike Enter
Record Will Appear for Viewing
Then Strike ESC to
Make the Record Current   0
```

00218812046789 PATIENT,TEST

[ENTER]

118

```
IF RECORD NOT IN LIST STRIKE ESC ELSE MAKE SELECTION AND STRIKE ENTER
                    DIAGNOSIS LIST FOR PATIENT
      MORPHOLOGY DIAGNOSIS          MORPH CODE      TOPOGRAPHY CODE
  OSTEOSARCOMA                       9180/3            40.9

  For Patient: 00218812046789  PATIENT,TEST
  To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape
IF RECORD NOT IN LIST STRIKE ESC ELSE MAKE SELECTION AND STRIKE ENTER
00218812046789  PATIENT,TEST
```

[↓] to diagnosis matching that listed on the patient's FOLLOW-UP RECORD (paper abstract)
[ENTER]

-OR-

[ESC], [ENTER], AND CONSULT WITH YOUR DATA MANAGER if no diagnosis listed for the patient matches the diagnosis listed on the FOLLOW-UP RECORD.

```
THIS IS REQUESTED PATIENT DIAGNOSIS RECORD FOR VIEWING ONLY. STRIKE ESCAPE
                      Data Base Options
              MAY REQUIRE IDENTIFICATION OF PATIENT
                 Update Patient Diagnosis Record
                    Record will be Changed
 PATIENT ID NUMBER              PTID    :00218812046789
 MORPHOLOGY ICD CODE            MDXID   :9180/3
 MORPHOLOGY DIAGNOSIS           MDXLIT  :OSTEOSARCOMA
 TOPOGRAPHY ICD CODE            TDXID   :40.0
 TOPOGRAPHY DIAGNOSIS           TDXLIT  :LONG BONES OF UPPER LIMB,SCAPULA
 DATE OF DIAGNOSIS yyyymmdd     DTDX    :19920401
 INSTITUTION REPORTING THIS DX  INST    :002
 DISEASE CATEGORY NUMBER        DISNO   : 20
 DISEASE CATEGORY LITERAL       DISLIT  :BONE AND JOINT TUMORS
 TREATMENT CODE                 RX      : 0
 TREATMENT LITERAL              RXLIT   :
 TREATMENTS: SG=SURGERY; XRX=RADIATION THERAPY; CH=CHEMOTHERAPY; ORX=OTHER
            DO NOT WRITE INTO THESE FIELDS. FOR INFORMATION ONLY
 POINTER TO SPECIAL TERMS       SPECPTR:  0
 POINTER TO DISEASE CATEGORY    CATPTR :  30      PRESS F5 FOR SUMMARY
THIS IS REQUESTED PATIENT DIAGNOSIS RECORD FOR VIEWING ONLY. STRIKE ESCAPE
00218812046789  PATIENT,TEST              OSTEOSARCOMA
```

EXAMINE the diagnostic information listed on the patient's FOLLOW-UP RECORD (paper abstract) and that displayed on the computer screen. If the morphology, topography, and date of diagnosis match:
[ESC]

-OR-

GO TO PAGE 36 if the diagnostic information does not match.

119

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
O
                WAS CORRECT PATIENT/
              DIAGNOSIS RECORD FOUND?

                1 = YES; 0 = NO
                      0
E                                        ata
Edit
E
Edit                                     ata

View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

[1]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
O
                WAS CORRECT PATIENT/
              DIAGNOSIS RECORD FOUND?

                1 = YES; 0 = NO
                      1
E                                        ata
Edit
E
Edit                                     ata

View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

[ENTER]

120

```
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

Patient Related Data Input

Options for Patient Data Input

Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Follow-Up Data
nt Commission Data

tient Summary

ESC; F1 for Help
```

```
NO FOLLOW-UP RECORD FOR THIS
DIAGNOSIS IN FILE

ENTER
0 = RETURN TO MENU WITHOUT ACTION
1 = CREATE NEW FOLLOW-UP RECORD
1
```

00218812046789 PATIENT,TEST

[1]
[ENTER]

```
SELECT INSTITUTION CODE FROM LIST

REPORTING INSTITUTIONS

NAME OF INSTITUTION                INSTITUTION CODE
Kansas University Medical Center   001
Semmelweis Univ. Medical School    002
National Inst. of Neurosurgery     003

For Patient: 00218812046789  PATIENT,TEST
To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape
```

00218812046789 PATIENT,TEST

[↓] to institution listed on patient's FOLLOW-UP RECORD (paper abstract)
[ENTER]

121

```
SELECT INSTITUTION CODE FROM LIST
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Optio                                  Input
                 REPORTING
            Id   INSTITUTION CODE      nt
                      IS
       Edit/         002              gnosis
   Edit/Vie          0               ific Data
       Edit/                          Data
   Edit/Vie                          sion Data
View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

[ENTER]

```
Record will be Added      UPDATE FOLLOW-UP RECORD (Linked to  69,856)
  PATIENT ID NUMBER                          PTID       :00218812046789
  INSTITUTIONAL  IDENTIFICATION NUMBER       INSTID     :002
  DATE OF THIS FOLLOWUP  yyyymmdd            DTFU       :
  PATIENT VITAL STATUS                       PT STATUS  : 0
     (2 = Dead; 1 = Alive;  9 = Unknown)
  DATE OF DEATH yyyymmdd                     DOD        :
  WAS AUTOPSY PERFORMED?                     AUTOPSY    :0
     (2 = No; 1 = Yes; 9 = Unknown)
  ICD CODE FOR CAUSE OF DEATH                COD        :
     (Use 4 digit code from ICD 9 to record cause of death DAM 3.128)
  TUMOR REGISTRY CODE FOR CAUSE OF DEATH                :
(0=DEAD,OTHER THAN CA; 1=DEAD,SAME CA; 2=DEAD,OTHER CA; 3=DEAD UNKNOWN CAUSE)
  FUNCTIONAL STATUS                          FUNCT STAT:0
     (1 = Normal activity; 2 = Symptomatic and Ambulatory;
      3 = Ambulatory more than 50% of the time, occasionally assisted;
      4 = Ambulatory less than 50% of the time, nursing care needed;
      5 = Bedridden, may need hospitalization; 8 = Not applicable,dead;
      9 = Unknown or unspecified.)
  TUMOR STATUS                               TUMOR STAT:0
F1=Help    (1 = No evidence of this cancer; 2 = Evidence of this cancer;
F5=Summary  9 = Unknown, Indeterminate whether this cancer is present.)
```

00218812046789 PATIENT,TEST OSTEOSARCOMA

[ENTER] X 3

122

```
Record will be Added      UPDATE FOLLOW-UP RECORD (Linked to  69,856)
  PATIENT ID NUMBER                          PTID       :00218812046789
  INSTITUTIONAL  IDENTIFICATION NUMBER       INSTID     :002
  DATE OF THIS FOLLOWUP  yyyymmdd            DTFU       :19930503
  PATIENT VITAL STATUS                       PT STATUS : 1
     (2 = Dead; 1 = Alive;  9 = Unknown)
  DATE OF DEATH yyyymmdd                     DOD        :
  WAS AUTOPSY PERFORMED?                     AUTOPSY    :0
     (2 = No; 1 = Yes; 9 = Unknown)
  ICD CODE FOR CAUSE OF DEATH                COD        :
     (Use 4 digit code from ICD 9 to record cause of death DAM 3.128)
  TUMOR REGISTRY CODE FOR CAUSE OF DEATH                :
(0=DEAD,OTHER THAN CA; 1=DEAD,SAME CA; 2=DEAD,OTHER CA; 3=DEAD UNKNOWN CAUSE)
  FUNCTIONAL STATUS                          FUNCT STAT:2
     (1 = Normal activity; 2 = Symptomatic and Ambulatory;
      3 = Ambulatory more than 50% of the time, occasionally assisted;
      4 = Ambulatory less than 50% of the time, nursing care needed;
      5 = Bedridden, may need hospitalization; 8 = Not applicable,dead;
      9 = Unknown or unspecified.)
  TUMOR STATUS                               TUMOR STAT:2
F1=Help    (1 = No evidence of this cancer; 2 = Evidence of this cancer;
F5=Summary  9 = Unknown, Indeterminate whether this cancer is present.)
```

00218812046789 PATIENT,TEST OSTEOSARCOMA

KEY IN PATIENT DATA from the patient's FOLLOW-UP RECORD (paper abstract).
[ENTER] or ↓ after keying each data item.
[Print Screen] after entering last data item.
[CTRL-ENTER] to input data and go on to the next screen.

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

123

* * * * **WHAT TO DO IF. . .** * * * *

THE PATIENT'S DIAGNOSIS IN THE COMPUTER DOES NOT MATCH THE DIAGNOSIS ON THE FOLLOW-UP RECORD:

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
O
WAS CORRECT PATIENT/
DIAGNOSIS RECORD FOUND?
1 = YES; 0 = NO
0
E
Edit                ata
E
Edit                ata
View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

[O]
[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient
Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Follow-Up Data
nt Commission Data
tient Summary
ESC; F1 for Help
REQUESTED PATIENT/DIAGNOSIS
NOT FOUND. MAKE NEW RECORD
Press enter to continue
1
```

00218812046789 PATIENT,TEST

[ENTER]

124

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
  Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

CONSULT WITH YOUR DATA MANAGER TO RESOLVE THIS PROBLEM.

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IV. Entering joint commission evaluation information

Joint commission evaluation (JCE) information on a patient may be entered anytime after the patient's Master Record and Diagnosis Record(s) have been entered into the POOH Registry and after one year has elapsed since the time of the patient's cancer diagnosis. Each JCE Record is linked to a specific Diagnosis Record for the patient and provides morbidity and mortality information useful for comparing groups of patients treated in Budapest hospitals and the University of Kansas Medical Center.

```
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

    Patient Related Data Input
      Select Printed Reports
        Erase Patient Files

REQUIRES NO IDENTIFICATION OF PATIENT
    Data File Editing Procedures
  Reference File Editing Procedures
 Create Disease Specific Sub-Fields
  Rectify Temporary Diagnosis Codes

Make Selection or ESC to Return; F1 for help
```

[ENTER]

```
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

    Patient Related Data Input

Options for Patient Data Input

Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

View Current Patient Summary

Make Selection or ESC; F1 for Help
```

The patient for whom you are entering JCE information should be displayed in the red line at the bottom of your computer screen. If no patient has been identified, refer to pages 8-16 of this manual for information on identifying the patient. After identifying the patient, **GO TO PAGE 39.**

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

[↓] to Edit/View/Enter Joint Commission Data
[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
PROCESS JOINT COMMISSION DATA
Correct patient master record must
be current. Record must be linked
to PATIENT/DIAGNOSIS record. This
must be selected as follows:
INSTRUCTIONS FOR SELECTING
PATIENT DIAGNOSIS RECORD
Scroll to Patient Diagnosis Record
If Not Found then Strike ESC
If Found then Strike Enter
Record Will Appear for Viewing
Then Strike ESC
Make the Record Current   0
```

00218812046789 PATIENT,TEST

[ENTER]

127

```
IF RECORD NOT IN LIST STRIKE ESC ELSE MAKE SELECTION AND STRIKE ENTER
┌──────────────────────────────────────────────────────────────────────┐
│                        DIAGNOSIS LIST FOR PATIENT                    │
├──────────────────────────────────────────────────────────────────────┤
│      MORPHOLOGY DIAGNOSIS          MORPH CODE      TOPOGRAPHY CODE   │
│  OSTEOSARCOMA                      9180/3            40.8            │
│                                                                      │
│                                                                      │
│                                                                      │
│                                                                      │
│                                                                      │
│                                                                      │
│                                                                      │
│                                                                      │
│                                                                      │
│                                                                      │
├──────────────────────────────────────────────────────────────────────┤
│ For Patient: 00218812046789  PATIENT,TEST                            │
│ To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape │
└──────────────────────────────────────────────────────────────────────┘
IF RECORD NOT IN LIST STRIKE ESC ELSE MAKE SELECTION AND STRIKE ENTER
00218812046789  PATIENT,TEST
```

[↓] to diagnosis matching that listed on the patient's JOINT COMMISSION EVALUATION RECORD (paper abstract)
[ENTER]

-OR-

[ESC], [ENTER], AND CONSULT WITH YOUR DATA MANAGER if no diagnosis listed for the patient matches the diagnosis listed on the JOINT COMMISSION EVALUATION RECORD.

```
THIS IS REQUESTED PATIENT DIAGNOSIS RECORD FOR VIEWING ONLY. STRIKE ESCAPE
                    Data Base Options
          MAY REQUIRE IDENTIFICATION OF PATIENT
┌──────────────────────────────────────────────────────────────────────┐
│                    Update Patient Diagnosis Record                   │
│                        Record will be Changed                        │
│ PATIENT ID NUMBER                PTID   :00218812046789              │
│ MORPHOLOGY ICD CODE              MDXID  :9180/3                      │
│ MORPHOLOGY DIAGNOSIS             MDXLIT :OSTEOSARCOMA                │
│ TOPOGRAPHY ICD CODE              TDXID  :40.0                        │
│ TOPOGRAPHY DIAGNOSIS             TDXLIT :LONG BONES OF UPPER LIMB,SCAPULA │
│ DATE OF DIAGNOSIS yyyymmdd       DTDX   :19920401                    │
│ INSTITUTION REPORTING THIS DX    INST   :002                         │
│ DISEASE CATEGORY NUMBER          DISNO  : 20                         │
│ DISEASE CATEGORY LITERAL         DISLIT :BONE AND JOINT TUMORS       │
│ TREATMENT CODE                   RX     : 0                          │
│ TREATMENT LITERAL                RXLIT  :                            │
│ TREATMENTS: SG=SURGERY; XRX=RADIATION THERAPY; CH=CHEMOTHERAPY; ORX=OTHER │
│             DO NOT WRITE INTO THESE FIELDS. FOR INFORMATION ONLY     │
│ POINTER TO SPECIAL TERMS         SPECPTR:   0                        │
│ POINTER TO DISEASE CATEGORY      CATPTR :  30      PRESS F5 FOR SUMMARY │
└──────────────────────────────────────────────────────────────────────┘
THIS IS REQUESTED PATIENT DIAGNOSIS RECORD FOR VIEWING ONLY. STRIKE ESCAPE
00218812046789  PATIENT,TEST              OSTEOSARCOMA
```

EXAMINE the diagnostic information listed on the patient's JOINT COMMISSION EVALUATION RECORD (paper abstract) and that displayed on the computer screen. If the morphology, topography, and date of diagnosis match:
[ESC]

-OR-

GO TO PAGE 45 if the diagnostic information does not match.

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
O
                WAS CORRECT PATIENT/
              DIAGNOSIS RECORD FOUND?

E                1 = YES; 0 = NO
Edit                   0                    ata
E
Edit                                        ata

          View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

[1]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
O
                WAS CORRECT PATIENT/
              DIAGNOSIS RECORD FOUND?

E                1 = YES; 0 = NO
Edit                   1                    ata
E
Edit                                        ata

          View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

[ENTER]

129

```
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

Patient Related Data Input

Options for Patient Data Input

Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Follow-Up Data
nt Commission Data

tient Summary

ESC; F1 for Help
```

```
NO JOINT COMMISSION RECORD FOR
THIS DIAGNOSIS INFILE

ENTER
0 = RETURN TO MENU WITHOUT ACTION
1 = MAKE NEW JOINT COMMISSION
RECORD
1
```

00218812046789 PATIENT,TEST

[1]
[ENTER]

```
SELECT INSTITUTION CODE FROM LIST

REPORTING INSTITUTIONS

NAME OF INSTITUTION                INSTITUTION CODE
Kansas University Medical Center   001
Semmelweis Univ. Medical School    002
National Inst. of Neurosurgery     003

For Patient: 00218812046789  PATIENT,TEST
To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape
```

00218812046789 PATIENT,TEST

[↓] to institution listed on patient's JOINT COMMISSION EVALUATION RECORD (paper abstract)
[ENTER]

```
SELECT INSTITUTION CODE FROM LIST
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

Patient Related Data Input

Optio                                  Input
                 REPORTING
          Id  INSTITUTION CODE         nt
                    IS
     Edit/        002                  gnosis
  Edit/Vie        0                    ific Data
     Edit/                             Data
  Edit/Vie                             sion Data

View Current Patient Summary

Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

[ENTER]

```
                    Joint Commission Evaluation Form
                         Record will be Changed
PATIENT ID NUMBER            PTID: 00218812046789      PRESS F5 FOR SUMMARY
DATE OF THIS RECORD:            DATE OF DEATH:yyyymmdd
JOINT COMMISSION EVALUATION DATA FOR THIS DIAGNOSIS DATE: 19920401 yyyymmdd
Number of Days in Hospital During First 365 Days After This Diagnosis:  0
DATE OF RELAPSE:          yyyymmdd
-------------------------------------------------------------------------
Cause of Early Death | Morbidity During First 365 Days After This Diagnosis
A. This Cancer : 0   |     A. Bleeding (Life Threatening)        :0
B. Bleeding    : 0   |     B. Infection (Life Threatening)       :0
C. Infection   : 0   |     C. Other Cause (Life Threatening)     :0
D. Other Cause : 0   |
KEY TO JOINT COMMISSION DATA ENTRIES:   1 = Yes; 2 = No; 9 = DK
          DO NOT WRITE INTO THIS FIELD. FOR INFORMATION ONLY
            POINTER TO PATIENT DIAGNOSIS RECORD  69,856

Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST OSTEOSARCOMA

KEY IN PATIENT DATA from the patient's JOINT COMMISSION EVALUATION RECORD (paper abstract).
[ENTER] or ↓ after keying each data item.

131

```
                    Joint Commission Evaluation Form
                          Record will be Added
PATIENT ID NUMBER            PTID: 00218812046789      PRESS F5 FOR SUMMARY
DATE OF THIS RECORD: 19930524   DATE OF DEATH:yyyymmdd
JOINT COMMISSION EVALUATION DATA FOR THIS DIAGNOSIS DATE: 19920401 yyyymmdd
Number of Days in Hospital During First 365 Days After This Diagnosis: 34
DATE OF RELAPSE:          yyyymmdd
-------------------------------------------------------------------------
Cause of Early Death | Morbidity During First 365 Days After This Diagnosis
A. This Cancer : 0   |     A. Bleeding (Life Threatening)        :2
B. Bleeding    : 0   |     B. Infection (Life Threatening)       :1
C. Infection   : 0   |     C. Other Cause (Life Threatening)     :2
D. Other Cause : 0   |
KEY TO JOINT COMMISSION DATA ENTRIES:   1 = Yes; 2 = No; 9 = DK
            DO NOT WRITE INTO THIS FIELD. FOR INFORMATION ONLY
              POINTER TO PATIENT DIAGNOSIS RECORD  69,856

                 Make Selection or ESC; F1 for Help

00218812046789  PATIENT,TEST              OSTEOSARCOMA
```

[Print Screen] after entering last data item.
[CTRL-ENTER] to input data and go on to the next screen.

```
                    Data Base Options
              MAY REQUIRE IDENTIFICATION OF PATIENT
                 Patient Related Data Input
                 Options for Patient Data Input
                    Identify Current Patient

                 Edit/View/Enter Tumor Diagnosis
              Edit/View/Enter Disease Specific Data
                 Edit/View/Enter Follow-Up Data
              Edit/View/Enter Joint Commission Data

                 View Current Patient Summary
                 Make Selection or ESC; F1 for Help

00218812046789  PATIENT,TEST
```

[ESC] X 2 to exit Registry program, if desired.

* * * * WHAT TO DO IF. . . * * * *

THE PATIENT'S DIAGNOSIS IN THE COMPUTER DOES NOT MATCH THE DIAGNOSIS ON THE JOINT COMMISSION EVALUATION RECORD:

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
O
WAS CORRECT PATIENT/
DIAGNOSIS RECORD FOUND?
1 = YES; 0 = NO
0
E                                ata
Edit
E
Edit                             ata
View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

[O]
[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient
Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Follow-Up Data
nt Commission Data
tient Summary
ESC; F1 for Help
```

```
REQUESTED PATIENT/DIAGNOSIS
NOT FOUND. MAKE NEW RECORD
Press enter to continue
2
```

00218812046789 PATIENT,TEST

[ENTER]

133

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data

View Current Patient Summary
Make Selection or ESC; F1 for Help
```

00218812046789 PATIENT,TEST

CONSULT WITH YOUR DATA MANAGER TO RESOLVE THIS PROBLEM.

* * * HOW TO ENTER TREATMENT DATA * * *

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
    Patient Related Data Input
      Select Printed Reports
        Erase Patient Files

REQUIRES NO IDENTIFICATION OF PATIENT
    Data File Editing Procedures
  Reference File Editing Procedures
 Create Disease Specific Sub-Fields
  Rectify Temporary Diagnosis Codes

Make Selection or ESC to Return; F1 for help
```

↓ to Patient Related Data Input
[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
    Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

   Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
   Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data
        Enter Treatment Data

     View Current Patient Summary
Make Selection or ESC; F1 for Help
```

↓ Identify Current Patient
[ENTER]

135

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edi                                  Data
Ma                                   lp
```

```
IDENTIFY CURRENT PATIENT
 1 = NEW PATIENT INPUT

 2 = ESTABLISHED PATIENT

          2
 0 = ABORT STEP
```

[2]
[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Pa
Identify Cu

Edit/View/Ente
Edit/View/Enter D
Edit/View/Ente
Edit/View/Enter J
Enter Tre

View Current
Make Selection o
```

```
SELECT SOURCE FOR ID NUMBER
 FOR ESTABLISHED PATIENT

 1 = ENTER NUMBER FROM
     KEYBOARD
 2 = SEARCH FOR NUMBER BY
       LAST NAME
 3 = SEARCH ENTIRE MASTER
       LIST

          3
```

[3]
[ENTER]

136

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data
Enter Treatment Data

View Current Patient Summary
Make Selection or ESC; F1 for Help
```

0019097531 ANNA,BEN

↓ to Enter Treatment Data
[ENTER]

```
DIAGNOSIS LIST FOR PATIENT
MORPHOLOGY DIAGNOSIS        MORPH CODE    TOPOGRAPHY CODE
ACUTE LYMPHOBLASTIC LEUKEMIA  9821/3        42.1

For Patient: 0019097531      ANNA,BEN
To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape
```

0019097531 ANNA,BEN ACUTE LYMPHOBLASTIC LEUKEMIA

↓ to correct diagnosis
[ENTER]

```
Data Base Options

Select Treatment Combination
CURRENT RX CODE: 0 TREATMENT:
SG=Surgery; XRX=Radiotherapy; CH=Chemotherapy; ORX=Other
No Treatment
Surgery
Radiotherapy
Chemotherapy
Other Treatment
Surgery + Radiotherapy
Surgery + Chemotherapy
Surgery + Other Treatment
Radiotherapy + Chemotherapy
Radiotherapy + Other Treatment
Surgery + Radiotherapy + Chemotherapy
Surgery + Radiotherapy + Other Treatment
Surgery + Chemotherapy + Other Treatment
Surgery + Radiotherapy + Chemotherapy + Other Treatment
Radiotherapy + Chemotherapy + Other Treatment
Chemotherapy + Other Treatment

0019097531      ANNA,BEN                ACUTE LYMPHOBLASTIC LEUKEMIA
```

↓ to treatment(s) given patient
[ENTER]

```
Data Base Options

Select Treatment Combination
CURRENT RX CODE: 0 TREATMENT:
SG=Surgery; XRX=Radiotherapy; CH=Chemotherapy; ORX=Other
No Treatment
Surgery
Radiotherapy
Chemotherapy
Other Treatme
Surgery + Radioth
Surgery + Chemoth
Surgery + Other Tr
Radiotherapy + Chem
Radiotherapy + Other
Surgery + Radiotherapy +
Surgery + Radiotherapy + O
Surgery + Chemotherapy + Other Treatment
Surgery + Radiotherapy + Chemotherapy + Other Treatment
Radiotherapy + Chemotherapy + Other Treatment
Chemotherapy + Other Treatment

ANOTHER DIAGNOSIS
FOR THIS PATIENT?
0 = NO
1 = YES
0

0019097531      ANNA,BEN                ACUTE LYMPHOBLASTIC LEUKEMIA
```

[1] + [ENTER] if treatment information for another diagnosis needs to be entered.

-or-

[0] + [ENTER] if no additional treatment information needs to be entered for this patient.

How to view the treatment information you've entered:

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT

Data File Edit Options

        View/Edit Patient Master File
      *View/Edit Patient Diagnosis Record
      *View/Edit Patient Follow Up Record
     *View/Edit Joint Commission Evaluation

  * = RECORDS SHOULD NOT BE ADDED TO THESE
      FILES FROM THIS MENU

Make Selection or ESC to Continue;F1 for Help
```

```
0019097531      ANNA,BEN                    ACUTE LYMPHOBLASTIC LEUKEMIA
```

↓ to View/Edit Patient Diagnosis Record
[ENTER]

```
                    Data Base Options
List of Patient Diagnoses
 PATIENT ID        MORPHOLOGY DIAGNOSIS              TOPOGRAPHY DIAGNOSIS
0019097531      ACUTE LYMPHOBLASTIC LEUKEMIA     BONE MARROW

Select Record  Ins to Add; Enter to Change; Del to Delete; ESC
```

```
0019097531      ANNA,BEN                    ACUTE LYMPHOBLASTIC LEUKEMIA
```

↓ to correct diagnosis
[ENTER]

```
                    Data Base Options
List of Patient Diagnoses
                    Update Patient Diagnosis Record
                        Record will be Changed
PATIENT ID NUMBER                PTID   :0019097531
MORPHOLOGY ICD CODE              MDXID  :9821/3
MORPHOLOGY DIAGNOSIS             MDXLIT :ACUTE LYMPHOBLASTIC LEUKEMIA
TOPOGRAPHY ICD CODE              TDXID  :42.1
TOPOGRAPHY DIAGNOSIS             TDXLIT :BONE MARROW
DATE OF DIAGNOSIS yyyymmdd       DTDX   :19930701
INSTITUTION REPORTING THIS DX    INST   :001
DISEASE CATEGORY NUMBER          DISNO  : 10
DISEASE CATEGORY LITERAL         DISLIT :LEUKEMIAS
TREATMENT CODE                   RX     : 4
TREATMENT LITERAL                RXLIT  :CHEMOTHERAPY (CH)
TREATMENTS: SG=SURGERY; XRX=RADIATION THERAPY; CH=CHEMOTHERAPY; ORX=OTHER
            DO NOT WRITE INTO THESE FIELDS. FOR INFORMATION ONLY
POINTER TO SPECIAL TERMS         SPECPTR:   0
POINTER TO DISEASE CATEGORY      CATPTR :  25      PRESS F5 FOR SUMMARY

0019097531      ANNA,BEN                    ACUTE LYMPHOBLASTIC LEUKEMIA
```

The treatment information you keyed is now included as part of the patient's diagnosis record.

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* * * HOW TO EDIT POOH REGISTRY RECORDS * * *

1- MODIFYING A PATIENT MASTER RECORD

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
    Patient Related Data Input
      Select Printed Reports
        Erase Patient Files
REQUIRES NO IDENTIFICATION OF PATIENT
    Data File Editing Procedures
  Reference File Editing Procedures
 Create Disease Specific Sub-Fields
  Rectify Temporary Diagnosis Codes
Make Selection or ESC to Return; F1 for help
```

↓ to Data File Editing Procedures
[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Data File Edit Options
    View/Edit Patient Master File
  *View/Edit Patient Diagnosis Record
  *View/Edit Patient Follow Up Record
  *View/Edit Joint Commission Evaluation
* = RECORDS SHOULD NOT BE ADDED TO THESE
    FILES FROM THIS MENU
Make Selection or ESC to Continue;F1 for Help
```

↓ to View/Edit Patient Master File
[ENTER]

Data Base Options

Patient Master File

PT ID NO	PT LAST NAME	PT FIRST NAME	MIDDLE NAME	ETH	SX	NAT
0018717713	[redacted]	JAMES	D	02	1	926
0018719990	[redacted]	AARON	J	01	1	926
0018726910	[redacted]	KAITLIN	I	01	2	926
0018903999	[redacted]	NEIL	M	01	1	926
0018906777	[redacted]	KEYLON	D	01	1	926
0018913741	[redacted]	DYLAN	L	02	1	926
0018924029	[redacted]	MICHELLE		02	2	926
0019000217	[redacted]	DANIELLE	M	01	2	926
0019001465	[redacted]	LOREN	T	01	2	926
0019013718	[redacted]	CHRISTINA	BETH	01	2	926
0019014233	[redacted]	LISA	A	01	2	926
0019014417	[redacted]	ELIZABETH	A	01	2	926
0019015622	[redacted]	MICHELLE		01	2	926
0019018042	[redacted]	ANDREAS	J	01	2	926

Ins to Add New Record; Enter to Change Record; Del to Delete Record; ESC

↓ to desired patient name
[ENTER]

```
      Data Input Form for Master     1ST THREE DIGITS  OF PATIENT ID NO
        Record will be Changed       MUST BE  ROOT INSTITUTION CODE NUMBER
Patient ID Number            PTID    :0018906777            RACE CODES
Patient Last Name            PLNAME  :[redacted]            01 = White
Patient First Name           PFNAME  :KEYLON                02 = Black
Patient Middle Name          PMNAME  :D                     03 = Asian/Orient
Mother Last Name (Maiden)    MLNAME  :                      04 = Hispanic
Mother First Name            MFNAME  :                      05 = Amerind,Esk
Mother Middle Name           MMNAME  :                      06 = Gypsy
Date of Birth                DOB     [redacted] yyyymmdd    98 = Other
Date of First Diagnosis      DOE     :19911028 yyyymmdd     99 = Unknown
Race/Ethnicity Code          RACE ETH:01
Sex (M=1;2=F;3=other;9=Unk)SEX       :1
Street Address               STREET  [redacted]
City Address                 CITY    :[redacted]
State of Residence           STATE   :[redacted]
Postal Code                  ZIP     :[redacted]      PRESS F1 FOR HELP
Country Code                 NATION  :926             PRESS F5 FOR SUMMARY
Father's Name:Last:                    First:                Middle Init:
Place of Birth--  City:                                 State:     Nation:
Postal Code of Birth         BZIP    :00000-0000
```

Make modifications as needed
[CTRL-ENTER]

2- MODIFYING A PATIENT DIAGNOSIS RECORD

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
    Patient Related Data Input
      Select Printed Reports
        Erase Patient Files
REQUIRES NO IDENTIFICATION OF PATIENT
    Data File Editing Procedures
  Reference File Editing Procedures
 Create Disease Specific Sub-Fields
  Rectify Temporary Diagnosis Codes
Make Selection or ESC to Return; F1 for help
```

↓ to Data File Editing Procedures
[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Data File Edit Options
    View/Edit Patient Master File
  *View/Edit Patient Diagnosis Record
  *View/Edit Patient Follow Up Record
 *View/Edit Joint Commission Evaluation
* = RECORDS SHOULD NOT BE ADDED TO THESE
    FILES FROM THIS MENU
Make Selection or ESC to Continue;F1 for Help
```

↓ to View/Edit Patient Diagnosis Record
[ENTER]

```
                    Data Base Options
List of Patient Diagnoses
 PATIENT ID        MORPHOLOGY DIAGNOSIS              TOPOGRAPHY DIAGNOSIS
0018717713       ACUTE LYMPHOBLASTIC LEUKEMIA     BONE MARROW
0018719990       ACUTE MYELOID LEUKEMIA           BONE MARROW
0018903999       MEDULLOMYOBLASTOMA               CEREBELLUM, NOS
0018906777       EPENDYMOMA
0018913741       ACUTE LYMPHOBLASTIC LEUKEMIA     BONE MARROW
0018924029       MEDULLOBLASTOMA
0019000217       ACUTE LYMPHOBLASTIC LEUKEMIA     BONE MARROW
0019001465       ACUTE LYMPHOBLASTIC LEUKEMIA     BONE MARROW
0019013718       ACUTE LYMPHOBLASTIC LEUKEMIA     BONE MARROW
0019014233       ACUTE LYMPHOBLASTIC LEUKEMIA     BONE MARROW
0019014417       ACUTE LYMPHOBLASTIC LEUKEMIA     BONE MARROW
0019018042       ACUTE LYMPHOBLASTIC LEUKEMIA     BONE MARROW
0019023841       ACUTE LYMPHOBLASTIC LEUKEMIA     BONE MARROW
0019024682       ACUTE LYMPHOBLASTIC LEUKEMIA     BONE MARROW
Select Record  Ins to Add; Enter to Change; Del to Delete; ESC
```

↓ to desired diagnostic record
[ENTER]

```
                    Data Base Options
List of Patient Diagnoses
                    Update Patient Diagnosis Record
                        Record will be Changed
   PATIENT ID NUMBER              PTID   :00218812046789
   MORPHOLOGY ICD CODE            MDXID  :9180/3
   MORPHOLOGY DIAGNOSIS           MDXLIT :OSTEOSARCOMA
   TOPOGRAPHY ICD CODE            TDXID  :40.0
   TOPOGRAPHY DIAGNOSIS           TDXLIT :LONG BONES OF UPPER LIMB,SCAPULA
   DATE OF DIAGNOSIS yyyymmdd     DTDX   :19920401
   INSTITUTION REPORTING THIS DX  INST   :002
   DISEASE CATEGORY NUMBER        DISNO  : 20
   DISEASE CATEGORY LITERAL       DISLIT :BONE AND JOINT TUMORS
   TREATMENT CODE                 RX     : 0
   TREATMENT LITERAL              RXLIT  :
   TREATMENTS: SG=SURGERY; XRX=RADIATION THERAPY; CH=CHEMOTHERAPY; ORX=OTHER
               DO NOT WRITE INTO THESE FIELDS. FOR INFORMATION ONLY
   POINTER TO SPECIAL TERMS       SPECPTR:   0
   POINTER TO DISEASE CATEGORY    CATPTR :  30      PRESS F5 FOR SUMMARY

00218812046789  PATIENT,TEST              OSTEOSARCOMA
```

Make modifications as needed (SEE PAGE 61 for how to update treatment data)
[CTRL-ENTER]

144

3- MODIFYING A PATIENT FOLLOW UP RECORD

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
    Patient Related Data Input
    Select Printed Reports
    Erase Patient Files
REQUIRES NO IDENTIFICATION OF PATIENT
    Data File Editing Procedures
    Reference File Editing Procedures
    Create Disease Specific Sub-Fields
    Rectify Temporary Diagnosis Codes
Make Selection or ESC to Return; F1 for help
```

↓ to Data File Editing Procedures
[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Data File Edit Options
    View/Edit Patient Master File
    *View/Edit Patient Diagnosis Record
    *View/Edit Patient Follow Up Record
    *View/Edit Joint Commission Evaluation
  * = RECORDS SHOULD NOT BE ADDED TO THESE
      FILES FROM THIS MENU
Make Selection or ESC to Continue;F1 for Help
```

↓ to View/Edit Patient Follow Up Record
[ENTER]

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Data Base Options

List of Follow-up Records

PT ID NO	REPORT CODE	FU DATE	CONDITION	DOD	TUMOR STATUS
0019210068	001	19920515	1		9
0019210131	001	19920603	2	19920603	9
0019210213	001	19930605	1		2
0019212258	001	19930218	2	19930218	2
0019216350	001	19930426	1		2
0019217322	001	19930504	1		2
0019217739	001	19930604	1		1
0019220436	001	19930524	1		2
0019221449	001	19921024	2	19921024	9
0019222659	001	19930601	1		2
0019225170	001	19930619	1		2
0019225725	001	19930702	1		2
0019227610	001	19930419	1		2
00218812046789	002	19930503	1		2

Enter to Change Record; Del to Delete Record; ESC

00218812046789 PATIENT,TEST OSTEOSARCOMA

↓ to desired follow-up record
[ENTER]

```
Record will be Changed     UPDATE FOLLOW-UP RECORD (Linked to  69,856)
   PATIENT ID NUMBER                          PTID       :00218812046789
   INSTITUTIONAL  IDENTIFICATION NUMBER       INSTID     :002
   DATE OF THIS FOLLOWUP  yyyymmdd            DTFU       :19930503
   PATIENT VITAL STATUS                       PT STATUS : 1
      (2 = Dead; 1 = Alive;  9 = Unknown)
   DATE OF DEATH yyyymmdd                     DOD        :
   WAS AUTOPSY PERFORMED?                     AUTOPSY    :0
      (2 = No; 1 = Yes; 9 = Unknown)
   ICD CODE FOR CAUSE OF DEATH                COD        :
      (Use 4 digit code from ICD 9 to record cause of death DAM 3.128)
   TUMOR REGISTRY CODE FOR CAUSE OF DEATH                :
(0=DEAD,OTHER THAN CA; 1=DEAD,SAME CA; 2=DEAD,OTHER CA; 3=DEAD UNKNOWN CAUSE)
   FUNCTIONAL STATUS                          FUNCT STAT:2
      (1 = Normal activity; 2 = Symptomatic and Ambulatory;
       3 = Ambulatory more than 50% of the time, occasionally assisted;
       4 = Ambulatory less than 50% of the time, nursing care needed;
       5 = Bedridden, may need hospitalization; 8 = Not applicable,dead;
       9 = Unknown or unspecified.)
   TUMOR STATUS                               TUMOR STAT:2
F1=Help    (1 = No evidence of this cancer; 2 = Evidence of this cancer;
F5=Summary  9 = Unknown, Indeterminate whether this cancer is present.)
```

00218812046789 PATIENT,TEST OSTEOSARCOMA

Make modifications as needed
[CTRL-ENTER]

4- MODIFYING A PATIENT JOINT COMMISSION EVALUATION RECORD

```
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

    Patient Related Data Input
      Select Printed Reports
        Erase Patient Files

REQUIRES NO IDENTIFICATION OF PATIENT
    Data File Editing Procedures
  Reference File Editing Procedures
 Create Disease Specific Sub-Fields
 Rectify Temporary Diagnosis Codes

Make Selection or ESC to Return; F1 for help
```

↓ to Data File Editing Procedures
[ENTER]

```
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

Data File Edit Options

      View/Edit Patient Master File
    *View/Edit Patient Diagnosis Record
    *View/Edit Patient Follow Up Record
    *View/Edit Joint Commission Evaluation

  * = RECORDS SHOULD NOT BE ADDED TO THESE
      FILES FROM THIS MENU

Make Selection or ESC to Continue;F1 for Help
```

↓ to View/Edit Joint Commission Evaluation
[ENTER]

147

Data Base Options

Joint Commission Evaluation

PT ID NO	DATE DX yyyymmdd	HOSP DAYS 1ST YEAR	----DEAD:------ CA	BLD	INF	OTH	--MORBIDITY:-- BLD	INF	OTH	DT DEATH yyyymmdd
0019210213	19920515	174	0	0	0	0	1	1	2	
0019212258	19920615	35	1	2	2	2	2	2	2	19930218
0019216350	19920810	27	0	0	0	0	2	2	2	
0019217322	19920822	87	0	0	0	0	2	1	2	
0019217739	19910701	0	0	0	0	0	9	9	9	
0019220436	19921005	88	0	0	0	0	2	1	2	
0019221449	19920723	0	1	2	2	2	2	2	2	19921024
0019222659	19921103	144	0	0	0	0	2	1	2	
0019225170	19921207	59	0	0	0	0	2	1	2	
0019225725	19920701	0	0	0	0	0	2	1	2	
0019227610	19921203	45	0	0	0	0	2	2	2	
00218812046789	19920401	34	0	0	0	0	2	1	2	

Abbreviations: CA=This cancer; BLD=Bleeding; INF=Infection; OTH=Other cause;
CODE:Yes = 1; NO = 2; Ins to Add; Enter to Update; Del to Delete;ESC

00218812046789 PATIENT,TEST OSTEOSARCOMA

↓ to desired joint commission evaluation record
[ENTER]

Joint Commission Evaluation Form
Record will be Changed

PATIENT ID NUMBER PTID: 00218812046789 PRESS F5 FOR SUMMARY
DATE OF THIS RECORD: 19930524 DATE OF DEATH:yyyymmdd
JOINT COMMISSION EVALUATION DATA FOR THIS DIAGNOSIS DATE: 19920401 yyyymmdd
Number of Days in Hospital During First 365 Days After This Diagnosis: 34
DATE OF RELAPSE: yyyymmdd

Cause of Early Death	Morbidity During First 365 Days After This Diagnosis
A. This Cancer : 0	A. Bleeding (Life Threatening) :2
B. Bleeding : 0	B. Infection (Life Threatening) :1
C. Infection : 0	C. Other Cause (Life Threatening) :2
D. Other Cause : 0	

KEY TO JOINT COMMISSION DATA ENTRIES: 1 = Yes; 2 = No; 9 = DK
DO NOT WRITE INTO THIS FIELD. FOR INFORMATION ONLY
POINTER TO PATIENT DIAGNOSIS RECORD 69,856

00218812046789	19920401	34	0	0	0	0	2	1	2

Abbreviations: CA=This cancer; BLD=Bleeding; INF=Infection; OTH=Other cause;
CODE:Yes = 1; NO = 2; Ins to Add; Enter to Update; Del to Delete;ESC

00218812046789 PATIENT,TEST OSTEOSARCOMA

Make modifications as needed
[CTRL-ENTER]

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5- MODIFYING TREATMENT DATA

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
    Patient Related Data Input
      Select Printed Reports
        Erase Patient Files

REQUIRES NO IDENTIFICATION OF PATIENT
    Data File Editing Procedures
  Reference File Editing Procedures
 Create Disease Specific Sub-Fields
  Rectify Temporary Diagnosis Codes

Make Selection or ESC to Return; F1 for help
```

↓ to Patient Related Data Input
[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
    Patient Related Data Input

Options for Patient Data Input
Identify Current Patient

   Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
   Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data
        Enter Treatment Data

     View Current Patient Summary

Make Selection or ESC; F1 for Help
```

↓ Identify Current Patient
[ENTER]

149

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Patient Data Input
Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edi                                  Data
Ma                                   lp

IDENTIFY CURRENT PATIENT
 1 = NEW PATIENT INPUT

 2 = ESTABLISHED PATIENT

          2
 0 = ABORT STEP
```

[2]
[ENTER]

```
Data Base Options
MAY REQUIRE IDENTIFICATION OF PATIENT
Patient Related Data Input
Options for Pa
Identify Cu
Edit/View/Ente
Edit/View/Enter D
Edit/View/Ente
Edit/View/Enter J
Enter Tre
View Current
Make Selection o

SELECT SOURCE FOR ID NUMBER
 FOR ESTABLISHED PATIENT

 1 = ENTER NUMBER FROM
     KEYBOARD
 2 = SEARCH FOR NUMBER BY
       LAST NAME
 3 = SEARCH ENTIRE MASTER
       LIST

          3
```

[3]
[ENTER]

PATIENT MASTER LIST

PT ID NO	LAST NAME	FIRST NAME	MIDDLE NAME
0019097531	ANNA	BEN	
001809876	BLACK	CHERRY	PIT
001920304	BLOSSOM	CHERRY	PIT
001796543	GERM	WHEAT	YUK
0011234567899999	GRANATE	PAM	
001854567	HEAD	TINY	
0018012345	PRUNE	PURPLE	PITTED

For Patient:
To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape

↓ to desired patient
[ENTER]

Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

Patient Related Data Input

Options for Patient Data Input

Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data
Enter Treatment Data

View Current Patient Summary

Make Selection or ESC; F1 for Help

0019097531 ANNA,BEN

↓ to Enter Treatment Data
[ENTER]

```
DIAGNOSIS LIST FOR PATIENT

      MORPHOLOGY DIAGNOSIS        MORPH CODE     TOPOGRAPHY CODE
ACUTE LYMPHOBLASTIC LEUKEMIA      9821/3           42.1

For Patient: 0019097531      ANNA,BEN
To Make Selection, Strike ENTER. If no Selection is Made, Strike ESCape
```

0019097531 ANNA,BEN

↓ to correct diagnosis
[ENTER]

```
Data Base Options

                Select Treatment Combination
CURRENT RX CODE: 4 TREATMENT: CHEMOTHERAPY (CH)
SG=Surgery; XRX=Radiotherapy; CH=Chemotherapy; ORX=Other
                        No Treatment
                           Surgery
                        Radiotherapy
                        Chemotherapy
                       Other Treatment
                   Surgery + Radiotherapy
                   Surgery + Chemotherapy
                  Surgery + Other Treatment
                 Radiotherapy + Chemotherapy
               Radiotherapy + Other Treatment
           Surgery + Radiotherapy + Chemotherapy
         Surgery + Radiotherapy + Other Treatment
         Surgery + Chemotherapy + Other Treatment
  Surgery + Radiotherapy + Chemotherapy + Other Treatment
       Radiotherapy + Chemotherapy + Other Treatment
               Chemotherapy + Other Treatment
```

0019097531 ANNA,BEN

↓ to treatment(s) given patient
[ENTER]

```
Data Base Options

Select Treatment Combination
CURRENT RX CODE: 4 TREATMENT: CHEMOTHERAPY (CH)
SG=Surgery; XRX=Radiotherapy; CH=Chemotherapy; ORX=Other
No Treatment
Surgery
Radiotherapy
Chemotherapy
Other Treatment
Surgery + Radiotherapy
Surgery + Chemotherapy
Surgery + Other Treatment
Radiotherapy + Chemotherapy
Radiotherapy + Other Treatment
Surgery + Radiotherapy + Chemothe
Surgery + Radiotherapy + Other Trea
Surgery + Chemotherapy + Other Trea
Surgery + Radiotherapy + Chemotherapy + Ot
Radiotherapy + Chemotherapy + Other T
Chemotherapy + Other Treatment

ANOTHER DIAGNOSIS
FOR THIS PATIENT?
0 = NO
1 = YES
0

0019097531      ANNA,BEN
```

[1] + [ENTER] if treatment information for another diagnosis needs to be changed.

-or-

[0] + [ENTER] if no additional treatment information needs to be changed for this patient.

```
Data Base Options

MAY REQUIRE IDENTIFICATION OF PATIENT

Patient Related Data Input

Options for Patient Data Input

Identify Current Patient

Edit/View/Enter Tumor Diagnosis
Edit/View/Enter Disease Specific Data
Edit/View/Enter Follow-Up Data
Edit/View/Enter Joint Commission Data
Enter Treatment Data

View Current Patient Summary

Make Selection or ESC; F1 for Help

0019097531      ANNA,BEN
```


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Appendix D.

HUNGARIAN NURSES TRAINED AT KUMC:

YEAR	SDP	NINS
1992	Andrea Zafir*	Erzsebet Nehez
	Rose Seres	Annamaria Peterfia*
1993	Judit Aranyosi	Judit Roth
	Krisztina Deak	Ildiko Nemeth
	Emma Bako	Annamaria Peterfia*
	Andrea Zafir*	Zsuzsanna Orisekne
1994	Gyrgyi Poor	Maria Pasek

* Andrea Zafir and Annamaria Peterfia participated in 2, 3-month training sessions each.

UNIVERSITY OF KANSAS MEDICAL CENTER

PEDIATRIC ONCOLOGY OUTREACH TO HUNGARY

NURSING SYLLABUS

BY

Pamela L. Cummings, R.N., B.S.N.

E. Lavonne Ridder, R.N., M.A./M.S.(N)

Susan Siemsen, R.N., M.A.

Tribahawan Vats, M.D.

Support for the Pediatric Oncology Outreach to Hungary project, by a grant from the U.S. Agency for International Development, is gratefully acknowledged.

Translated into Hungarian by:
John J. Kepes, M.D.

English and Hungarian transcription by:
Linda L. Rock, B.S.

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PREFACE

As a vision of selected Pediatric Oncology staff at the University of Kansas Medical Center, funds were allocated to facilitate onsite collaboration between oncology physicians and pediatric oncology nurses from both the National Institute of Neurosurgery and the Second Department of Pediatrics of the Semmelweis University Medical School in Budapest, Hungary, in an applied clinical research program to reduce excess mortality related to childhood cancer in Hungary.

This work was designed to facilitate a comprehensive holistic approach to care for the pediatric oncology client. The subsequent outline was developed by Pediatric Oncology Nurse Clinicians at the University of Kansas College of Health Sciences and Hospital, Kansas City, Kansas.

Enclosed you will find a detailed outline of care parameters that should prove helpful in effecting standards of care in the Pediatric Oncology Population. The comprehensiveness of this design will hopefully allow you to adapt care parameters to your individual client and institutional needs.

UNIVERSITY OF KANSAS
PEDIATRIC HEMATOLOGY ONCOLOGY

INTENDED LEARNING OUTCOMES

OBJECTIVES

1. Describe the development of the advanced roles in nursing.

2. Increase knowledge base regarding pediatric oncologic disease states.

3. Discuss current treatments for clients with pediatric cancers.

4. Utilize assessment skills in defining pediatric oncologic emergencies.

5. Utilize the problem solving process in correcting patient/family oncologic problems.

6. Discuss ways to increase resources to use in working with oncology patients.

OUTCOME CRITERIA

1. Through lecture, written materials, audiovisual aids and discussion the evolution of specialized and advanced roles in American nursing will be shared. Each learner will work along side a University of Kansas Pediatric Oncology Nurse Clinician, observing and assisting in their work. Evaluation will take place after return to home institution via observation of behavior changes and changing of the working climate.

2. By using written materials, lecture, audio visual aids, discussion and assisting with the care for children with the various disease states, current information about oncologic disease states and treatments will be shared. Evaluation will be in the form of paper and pencil exercises and observation on patient units and in the clinic setting.

3. Through demonstration, discussion, written materials, and audiovisual aids assessment problem solving methods will be presented. Evaluation will take place while assisting nurse clinicians and by observation and grading system utilizing an evaluation tool.

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UNIVERSITY OF KANSAS MEDICAL CENTER

PEDIATRIC ONCOLOGY OUTREACH TO HUNGARY

NURSING TIMETABLE

WEEK 1	-	Monday	-	Thursday - Orientation to clinical area
		Friday	-	Role of Nursing / Round - table discussion
WEEK 2	-	Monday	-	Clinical area
		Tuesday	-	Didactic Session: Nursing in the Advanced Role
		Wednesday	-	Clinical area
		Thursday	-	Physical Assessment
		Friday	-	Clinical area
WEEK 3	-	Monday	-	Clinical area
		Tuesday	-	Didactic Session: Pediatric Oncology Overview
		Wednesday	-	Clinical area
		Thursday	-	Didactic Session - Supportive Care Issues I
		Friday	-	Clinical area
WEEK 4	-	Monday	-	Clinical area
		Tuesday	-	Didactic Session - Supportive Care Issues II
		Wednesday	-	Clinical area
		Thursday	-	Didactic Session: Problems Unique to Children 1.) Pediatric Pain Assessment and Control 2.) Procedure Preparation 3.) Sedation
		Friday	-	Clinical area
WEEK 5	-	Monday	-	Clinical area
		Tuesday	-	Didactic Session - Psychosocial Issues Associated with Childhood Cancer
		Wednesday	-	Clinical area
		Thursday	-	Didactic Session: Continued Education
		Friday	-	Clinical area
WEEK 6	-	Nursing Rotation from In-patient to Out-patient setting Evaluation		
WEEK 7-11	-	Monday - Friday - Clinical area with application		
WEEK 12	-	Evaluation		

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IN - PATIENT

MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
8:00 9:30	Inpatient rounds with RN	8:00 9:30	---------->	8:00 9:30	---------->	8:00 9:30	---------->	8:00 9:30	---------->
9:30 10:00	Meet with staff, physician and residents	9:30 10:00	---------->	9:30 10:00	---------->	9:30 10:00	---------->	9:30 10:00	---------->
11:00	After rounds follow-up	11:00	---------->	11:00	---------->	11:00	---------->	11:00	---------->
12:00 1:00	Lunch	12:00 1:00	Lunch	12:00 1:00	Lunch	12:00 1:00	Lunch	12:00 1:00	Lunch
		1:30 4:00	Didactic Sessions			1:30 4:00	Didactic Sessions		
1:00 4:00	Patient/Parent Education Scheduling of patient admissions for following day			1:00 4:00	---------->			1:00 4:00	---------->

OUTPATIENT

MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
8:00 12:00	Pediatric Oncology Clinic	8:00 12:00		8:00 10:00	Inpatient Rounds	8:30 10:00		8:30 1:00	Pediatric Oncology Clinic
12:00 1:00	Lunch			12:00 1:00	Lunch	12:00 1:00	Lunch	12:00 1:00	Lunch
1:30 2:30	Clinic cleanup and documentation of data	1:30 4:00	Didactic Sessions			1:30 4:00	Didactic sessions		
2:30 3:30	Return of pt parent phone messages Coordination with community resources and correspondence			2:30 3:30	<--------->			2:30 3:30	<------->
3:30 4:30	Follow up Preparation for next day clinic			3:30 4:30	<--------->			3:30 4:30	<------->

NURSING AS AN ADVANCED ROLE

Pamela L. Cummings, R.N., B.S.N.

I. Historical perspective

A. Titles

1. Nurse Clinician
2. Clinical Nurse Specialist

B. Origin

1. Early as 1900's - nurses designated as specialists
2. Purpose
3. Postgraduate study

   a. Clinical Practice
   b. Education
   c. Administration
   d. Research

4. Factors contributing to the evolution of nursing as an advanced role

   a. functional preparation
   b. clinical preparation
   c. increase in hospital demands
   d. nursing shift from a private duty model to a supervisory model within a hospital bureaucratic structure

C. Development of Oncology Nursing as a Specialty

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ADVANCED PRACTICE STANDARDS IN ONCOLOGY NURSING

I. Professional Practice Standards

- Standard I. Direct Caregiver Function
- Standard II. Coordinator Function
- Standard III. Consultant Function
- Standard IV. Educator Function
- Standard V. Researcher Function
- Standard VI. Administrator Function

II. Professional Performance Standards

- Standard VII. Professional Development
- Standard VIII. Ethics
- Standard IX. Legal Issues
- Standard X. Quality Assurance
- Standard XI. Healthcare Policy

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CURRENT ISSUES IN NURSING

Lavonne Ridder R.N., M.A.

I. Career Development in Nursing

A. Phases

1. Fantasy
2. Tentative
3. Realistic
4. Anticipatory
5. Adjustment

B. Tasks

1. Crystallization
2. Specification
3. Implementation
4. Stabilization
5. Consolidation and Advancement

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II. Strategies for Changing Nursing Image

III. Nurses as Risk Takers

IV. Professional Power

V. Ethical Dilemma

VI. Nursing Research and Generating Nursing Knowledge

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OUTLINE OF A PEDIATRIC HEALTH HISTORY

Susan Siemsen, R.N.M.A.

Identifying information

1. Name
2. Address
3. Telephone
4. Age and birth date
5. Race
6. Sex
7. Religion
8. Nationality
9. Date of interview
10. Informant

Chief complaint

Present illness

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Personal / Social History

1. Home and community environment
2. Occupation and education of family members
3. Cultural and religious traditions
4. Marital and sexual history

Patient profile (summary)

1. Health status
2. Psychologic status
3. Socioeconomic status

GENERAL OUTLINE FOR NURSING ASSESSMENT

A. General

1. Measurements

   a. Height

   b. Weight

   c. Head circumference

   d. Vital signs

   e. Blood pressure

2. General appearance

3. Skin

4. Lymph glands

B. Review of Systems (ROS)

1. Head

2. Neck

3. Eyes

4. Ears

5. Mouth and throat

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6. Chest

7. Lungs

8. Heart

9. Abdomen

10. Genitalia

11. Back and extremities

C. Neurologic

1. Behavior

2. Cognitive-perceptual development

3. Motor functioning

4. Sensory functioning

   a. Hearing

   b. Vision

5. Cerebellar functioning

6. Reflexes

7. Cranial nerves

8. "Soft" signs

D. Developmental screening

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E. Past history

1. Birth history
2. Feeding history
3. Previous illnesses, injuries, or operations
4. Allergies
5. Current medications
6. Immunizations
7. Growth and development
8. Habits

F. Review of systems

1. General
2. Integument
3. Head
4. Eyes
5. Ears
6. Nose
7. Mouth, teeth, tongue, and gums

8. Throat and neck

9. Chest

10. Respiratory

11. Cardiovascular

12. Gastrointestinal

13. Genitourinary

14. Gynecologic (obstetric)

15. Musculoskeletal

16. Neuropsychiatric

17. Lymphatic and hematologic

18. Endocrine

G. Family history

1. Family pedigree

2. Familial diseases and congenital anomalies

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GENERAL GUIDELINES FOR PHYSICAL EXAMINATION DURING CHILDHOOD

Perform examination in appropriate, nonthreatening area.

- Have room well lit and decorated with neutral colors.
- Have room temperature comfortably warm.
- Place all strange and potentially frightening equipment out of sight.
- Have some toys, dolls, stuffed animals, and games available for the child.
- If possible, have rooms decorated and equipped for different age children.
- Provide privacy, especially for school-age children and adolescents.
- Check that equipment and supplies are working properly and are accessible to avoid disruption.

Provide time for play and becoming acquainted.

- Talking to the nurse.
- Making eye contact.
- Accepting the offered equipment.
- Allowing physical touching.
- Choosing to sit on examining table rather than parent's lap.

If signs of readiness are not observed, use the following techniques.

- Talk to the parents while essentially "ignoring" the child: gradually focus on the child or a favorite object, such as a doll.
- Make complimentary remarks about the child, such as his appearance, dress, or a favorite object.
- Tell a funny story or play a simple trick
- Have a nonthreatening "friend" available, such as a hand puppet to "talk" to the child for the nurse.

If the child refuses to cooperate, use the following techniques:

- Assess reason for uncooperative behavior: consider that a child who is unduly afraid of a male examiner may have had a previous traumatic experience, including sexual abuse.
- Try to involve child and parent in process or if appropriate, ask parent to leave.
- Avoid prolonged explanations about examining procedure.
- Use a firm, direct approach regarding expected behavior.
- Perform examination as quickly as possible.
- Have attendant gently restrain child.
- Minimize any disruptions or stimulation.

  Limit number of people in room.

  Use isolated room.

  Use quiet, calm, confident voice.

Begin the examination in a nonthreatening manner for young children or children who are fearful.

- Use those activities that can be presented as games, such as test for cranial nerves or parts of the Denver Developmental Screening Test (DDST).
- Use approaches such as "Simon says" to encourage child to make a face, squeeze a hand, stand on one foot, and so on.
- Use the "paper doll" technique.

  Lay the child supine on an examining table or floor that is covered with a large sheet of paper.

  Trace around the child's body outline.

  Use the body outline to demonstrate what will be examined, such as drawing a heart and listening with the stethoscope before performing the activity on the child.

If several children in the family will be examined, begin with the most cooperative child.

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Involve child in the examination process:

- Provide choices, such as sitting on the table or in the parent's lap.
- Allow to handle, or hold equipment.
- Encourage to use equipment on a doll, family member, or examiner.
- Explain each step of the procedure in simple language.

Examine child in a comfortable and secure position.

- Sitting in parent's lap.
- Sitting upright if in respiratory distress.

Proceed to examine the body in an organized sequence (usually head to toe) with following exceptions:

- Alter sequence to accommodate needs of different age children
- Examine painful areas last.
- In emergency situation, examine vital functions, (airway, breathing, and circulation) and injured area first.

Reassure child throughout examination, especially bodily concerns that arise during puberty.

Discuss the findings with the family at the end of the examination.

Praise child for cooperation during examination: give reward such as small toy or sticker.

THE REVIEW OF SYSTEMS

GENERAL - Overall state of health, fatigue, recent and/or unexplained weight gain or loss, period of time for either, contributing factors (change of diet, illness, altered appetite), exercise tolerance, fevers (time of day), frequent infections, general ability to carry out activities of daily living

INTEGUMENT - Pruritus, pigment or other color changes, acne, eruptions, rashes (location), tendency to bruising, petechiae, excessive dryness, general texture, disorders or deformities of nails, hair growth or loss, hair color change (for adolescent, use of hair dyes or other potentially toxic substances, such as hair straighteners)

HEAD - Headaches, dizziness, injury (specific details)

EYES - Visual problems (ask about behaviors indicative of blurred vision, such as bumping into objects, clumsiness, sitting very close to television, holding a book close to the face, writing with head near desk, squinting, rubbing the eyes, bending the head in awkward position), "cross-eye" (strabismus), eye infections, edema of lids, excessive tearing, use of glasses or contact lenses, date of last optic examination

NOSE - Nosebleeds (epistaxis, constant or frequent running or stuffy nose, nasal obstruction (difficulty in breathing), sense of smell

EARS - Earaches, discharge, evidence of hearing loss (ask about behaviors, such as need to repeat request, loud speech, inattentive behavior), results of any previous auditory testing

MOUTH - mouth breathing, gum bleeding, toothaches, problems with toothbrushing, difficulty with teething (symptoms), last visit to dentist (especially if temporary dentition is complete)

THROAT - sore throats, difficulty in swallowing, choking (especially when chewing food - may be from poor chewing habits), hoarseness or other voice irregularities

NECK - pain, limitation of movement, stiffness, difficulty in holding head straight (torticollis), thyroid enlargement, enlarged nodes or other masses

CHEST - breast enlargement, discharge, masses, enlarged axillary nodes (for adolescent female, ask about self-breast examination)

RESPIRATORY - chronic cough, frequent colds (number per year), wheezing, shortness of breath at rest or on exertion, difficulty in breathing, sputum production, infections (pneumonia, tuberculosis), date of last chest x-ray examination

CARDIOVASCULAR - cyanosis or fatigue on exertion, history of heart murmur or rheumatic fever, anemia, date of last blood count, blood type, recent transfusion

GASTROINTESTINAL - (much of this in regard to appetite, food tolerance, and elimination habits has been asked elsewhere), concentrate on nausea, vomiting (not associated with eating may be indicative of brain tumor or increased intracranial pressure), jaundice or yellowing skin or sclera, belching, flatulence, recent change in bowel habits (blood in stools, change of color, diarrhea, or constipation)

GENITOURINARY - pain on urination, frequency, hesitancy, urgency, hematuria, nocturia, polyuria, unpleasant odor to urine, force of stream discharge, change in size of scrotum, (for adolescent, venereal disease, type of treatment), date of last urinalysis

GYNECOLOGIC - menarche, date of last menstrual period, regularity or problems with menstruation, vaginal discharge, pruritus, date and result of last Pap smear (include obstetric history as discussed under birth history when applicable), if sexually active, type of contraception

MUSCULOSKELETAL - weakness, clumsiness, lack of coordination, unusual movements, back or joint stiffness, muscle pains or cramps, abnormal gait, deformity, fractures, serious sprains, activity level

NEUROLOGIC - seizures, tremors, dizziness, loss of memory, general affect, fears, nightmares, speech problems, any unusual habits

ENDOCRINE - intolerance to weather changes, excessive thirst, excessive sweating, salty taste to skin, signs of early puberty

NEUROLOGIC ASSESSMENT

Mental status

PROCEDURE:

Observe behavior, mood, affect, general orientation to surroundings, level of consciousness

ASSESSMENT:

Motor functioning

PROCEDURE:

Test muscle strength, tone, and development

Test cerebellar functioning:

- **Finger-to-nose - With the child's arm extended, have touch nose with the index finger**
- **Heel-to-shin test - With child standing, have the child run the heel of one foot down the shin of the other leg**
- **Romberg test - Have child stand erect with feet together and eyes closed**
- **Have child touch tip of each finger with thumb in rapid succession**
- **Have child pat leg with first one side, then the other side of hand in rapid sequence**
- **Have child tap your hand with ball of foot as quickly as possible**

ASSESSMENT:

Sensory functioning

PROCEDURE:

Test vision and hearing

Sensory intactness:

- Touch skin lightly with a pin and have child point to stimulated area while keeping eyes closed

Sensory discrimination:

- Touch skin with pin and cotton; have child describe it as sharp or dull
- Touch skin with cold and warm object (such as metal and rubber heads of reflex hammer); have child differentiate between temperatures
- Using two pins, touch skin simultaneously with both or one pin; have child discriminate when one or two pins are used

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ASSESSMENT:

Reflexes (deep tendon)

PROCEDURE:

Biceps

- Hold the child's arm by placing the partially flexed elbow in your hand with the thumb over the antecubital space; strike your thumbnail with the hammer

Triceps

- Bend the arm at the elbow and rest the palm in your hand; strike the triceps tendon
- Alternate procedure - if the child is supine rest arm over chest and strike the triceps tendon

Brachioradialis

- Rest the forearm on the lap or abdomen, with the arm flexed at the elbow and palm down; strike the radius about 1 inch (depending on child's size) above the wrist

Knee jerk or patellar reflex

- Sit the child on the edge of the examining table or on parent's lap with the lower legs flexed at the knee and dangling freely; tap the patellar tendon just below the knee cap

Achilles

- Use the same position as for the knee jerk; support the foot lightly in your hand and strike the Achilles tendon

Ankle clonus

Kernig sign

- Flex child's leg at hip and knee while supine; note pain or resistance

Brudzinski sign

- With child supine, flex the head; note pain and involuntary flexion of hip and knees

Cranial nerves

- See assessment of cranial nerves

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NEUROLOGIC ASSESSMENT

COMMENTS:

- Subjective impressions are based on observation throughout the examination
- Objective findings can be attained through developmental testing such as DDST

USUAL FINDINGS:

- Performs each test successfully with eyes opened and closed

COMMENTS:

- May be difficult to test in children younger than preschool age
- Note any awkwardness or lack of coordination in performance

USUAL FINDINGS:

- **Romberg test - Does not lean to side or fall**

COMMENTS:

- **Falling or leaning to one side is abnormal and is called the *Romberg sign***

USUAL FINDINGS:

- **Localizes pinprick**

COMMENTS:

- **Use sterile pin or other sharp object (toothpick), being careful not to puncture skin**
- **Compare sensation in symmetric area at both distal and proximal points**

USUAL FINDINGS:

- Able to distinguish types of sensation and temperature
- Minimal distance for discrimination of finger is about 2 to 3 mm

COMMENTS:

- Note difficulty in performing test, especially in older child

USUAL FINDINGS:

- Biceps - Partial flexion of forearm

COMMENTS:

- Use reinforcement techniques to increase reflex activity: For upper extremity reflexes - ask child to clench teeth or to squeeze thigh with the hand on the side not tested

USUAL FINDINGS:

- Triceps - Partial extension of forearm

COMMENTS:

- For lower extremity reflexes - have child lock fingers and pull one hand against the other or grip hands together

Usual grading of reflexes

Grade 0				0 Absent
Grade 1				+ Diminished
Grade 2			+	+ Normal
Grade 3		+	+	+ Brisker than normal
Grade 4	+	+	+	+ Hyperactive (clonus)

Note asymmetric, absent, diminished, or hyperactive reflexes

USUAL FINDINGS:

- Brachioradialis - Flexion of the forearm and supination (turning upward) of the palm

- Patellar - Partial extension of the lower leg

- Achilles - Plantar flexion of foot (foot pointing downward)

- Ankle clonus - Absence of beats

USUAL FINDINGS:

- Kernig - Absence of pain or resistance

COMMENTS:

- These special reflexes are elicited when meningeal irritation is suspected

USUAL FINDINGS:

- Brudzinski - Absence of pain or associated movements

COMMENTS:

- Positive signs require immediate referral
- Testing of cranial nerves may be done as part of the neurologic examination or integrated into assessment of each system, such as cranial nerves II, III, IV, and VI with the eye
- Cranial nerves can usually be tested in children of preschool age and older
- Note inability to perform any of the items correctly

Description of abnormal involuntary muscular movements

Term	Description
Ataxia	Gross incoordination, which may worsen with the eyes closed
Spasm	Unusual tenseness of the muscle mass
Spasticity	Prolonged and steady contraction of a muscle characterized by clonus (alternating relaxation and contraction of the muscle) and exaggerated reflexes
Rigidity	Inability to flex a joint
Tremors	Constant small movements

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Description of abnormal involuntary muscular movements (continued)

Term	Description
Twitching	Spasmodic movements of short duration
Choreiform movements	Quick, jerky, grossly uncoordinated, irregular movements that may disappear on relaxation
Dystonia	Slow twisting movements of limbs or trunk
Associated movements	Voluntary movement of one muscle accompanied by involuntary movement of another muscle
Mirroring movements	Same as associated movements except with symmetric muscle groups

PEDIATRIC ASSESSMENT

I. Assessment through history taking of the child and family

OUTLINE OF A PEDIATRIC HEALTH HISTORY

Identifying information

1. name
2. address
3. telephone
4. age and birthdate
5. race
6. sex
7. religion
8. nationality
9. date of interview
10. informant (the person providing the identifying information)

Chief Complaint (CC):

Represents the specific reason for the child's visit to the clinic, office, or hospital

Six guidelines for recording the CC:

1. limited brief statement
2. restricted to one or two symptoms
3. refers to concrete complaint
4. recorded in the child's or parent's own words
5. avoids the use of diagnostic terms or translation
6. states the duration of the symptoms

PRESENT ILLNESS (PI OR HPI) :

Narrative of the CC from its earliest onset through its progression to the present

Four Major Components:

1. details of onset
2. complete interval history
3. present status
4. reason for seeking help now

Analysis of a symptom

1. onset

    a. date of onset
    b. manner of onset (gradual or sudden)
    c. precipitating and predisposing factors related to onset (emotional disturbance, physical exertion, fatigue, bodily function, pregnancy, environment, injury, infection, toxins and allergens, therapeutic agents and so on.)

2. characteristics

    a. character
    b. location and radiation (of pain)
    c. intensity of severity
    d. timing (continuous or intermittent, duration of each)
    e. aggravating and relieving factors
    f. associated symptoms

3. course since onset

   a. incidence

      (1) single acute attack
      (2) recurrent acute attack
      (3) daily occurrences
      (4) periodic occurrences
      (5) continuous chronic episodes

   b. progress (better, worse, unchanged)

   c. effect of therapy

PAST HISTORY (PH) OR PAST MEDICAL HISTORY (PMH)

Contains information relating to all previous aspects of the child's health status and concentrates on several areas that are ordinarily deleted in the history of an adult, such as birth history, detailed feeding history, immunizations and growth and development.

1. Birth history

   a. mother's health during pregnancy
   b. the labor and delivery
   c. infants condition immediately after birth

2. Feeding history
   Varies depending on the child's age

   a. <u>infant feeding</u> - type of feeding (breast, formula) change in feeding habits time required for one feeding, appetite - quantity consumed, addition of vitamins, weight change, problems associated with feeding vomiting, diarrhea, colic, rumination, refusal to eat, "spitting up" remedies used for problems

   b. <u>older children</u> - "diet diary", elicit a feeding history by asking the parent to list "what the child ate yesterday" and was this a "typical day". Review the same detailed history as listed above beside infant feeding when applicable, plan appropriate counseling as indicated based upon the diet history and assessment, refer for a more complete nutritional evaluation by a Registered Dietician if indicated.

3. Previous Illnesses, Injuries, and Operations
   Illness

   a. Infectious
      onset, symptoms, course, duration
   b. Contagious Diseases: (childhood diseases)
      chicken pox, rubella (German measles), mumps, herpes zoster, CMV, Hepatitis. List onset, symptoms, course and duration

<u>Injuries</u>

List date, specific injury, treatment

<u>Operations</u>

List date, type of surgery, complications, surgeon/hospital

<u>Hospitalizations</u>

List date of admission, location, diagnosis, treatment, discharge date, physician

7,00

4. Current Medications:
   a. Allergies to drugs

   b. Current drug regimens: all medications should be listed including mane, dose, schedule duration, and reason for administration

5. Immunizations:

   a. A record of all immunizations and "baby shots" is essential

   b. All immunizations and "boosters" should be listed: state name of specific disease, dosage, age when administered, and occurrence of any reaction following the immunization

   c. Inquire about previous administration of any horse serum or other foreign serum, recent administration of gammaglobulin or blood transfusion or sensitivity to egg albumin

   d. Inquire about tuberculide testing (TB tiru or PPD). If testing was done record the child's positive or negative intradermal reaction.

6. Growth and Development:

   Important previous growth patterns to record are:

   a. approximate weight at 6 months, 1 year, 2 years, and 5 years of age

   b. approximate length at age 1 and 4 years

   c. dentition, including age of onset, number or teeth

Developmental Milestones:

a. age of holding up head steadily
b. age of sitting alone without support
c. age of walking alone without support
d. age of saying first words with meaning
e. present grade level in school
f. scholastic grades
g. interaction with other children, peers and adults

Screening tools: DDST - Denver Developmental Screening Test

7. Habits

a. behaviors patterns; such as nailbiting, thumb-sucking, pica, rituals ("security"blanket or toy), and unusual movements
b. activities of daily living; hour of sleeping and arising, duration of nighttime sleep, naps, type and duration of exercise, regularity of stools and urination, age of toilet training, occurrences of daytime or nighttime bed-wetting
c. usual disposition as well as response to frustration
d. use or abuse of alcohol, drugs, coffee, and cigarettes
e. dental hygiene
f. safety habits of family

8. Review of systems:

a. a specific review of each body system, similar to the order of a physical exam

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9. Family History

a. primarily for the purpose of discovering the potential existence of hereditary or familial disease in the parents and children.

b. also include marital relationship, availability of support systems in extended relatives, and age relationships among siblings.

c. include the maternal and paternal parents, siblings, and offspring, information for each includes: age, state of health if living, cause of death if deceased, and any evidence of the following conditions:

heart disease
hypertension
cancer
diabetes mellitus
obesity
congenital anomalies
mental retardation
allergy
asthma
tuberculosis
sickle cell disease
convulsions
insanity or emotional problems
syphilis
rheumatic fever

10. Personal/Social History

Includes all the personal, social and economic factors that influence the child's and family's overall psychologic health

Focus on:

a. home and community environment
b. occupation and education of family members
c. cultural and religious traditions
d. geographic location
e. marital and sexual history of the parent and child
f. financial resources - insurance
g. school history and progress

11. Patient Profile:

Summary of the impression of the child's health status and the psychologic - socioeconomic variables that influence his total well-being

a. health status - such as, common health problems discovered during the interview

b. physchologic status - family problems such as divorce or separation

c. socioeconomic status - such as, living conditions and family financial status

12. Interval History - Return patient visit

S.O.A.P.:

a. **S**ubjective: Chief Complaint, Present Illness, Past Medical History and Review of System
b. **O**bjective: vital signs, physical exam, laboratory studies, x-rays
c. **A**ssessment: diagnosis - problem list
d. **P**lan: approach to solving problem list and follow-up

II. Physical assessment of the child

A. General Information:

Age-specific guidelines Table 1

Approaching the child

Age of the child frequently alters the sequence of performance. Use developmental and chronological age as the main criteria for assessing each body system.

Goals:

1. minimization of stress and anxiety associated with various body parts
2. fostering of a trusting relationship between examiner-child-parent
3. allowance for maximum preparation of child
4. maximization of accuracy and reliability of assessment findings.

B. Assessment skills:

The traditional four categories of assessment skills include inspection, palpation, percussion, and auscultation.

Each of these involves a set of tools to facilitate its performance, usefulness, and accuracy.

Inspection - sight, smell, hearing and sometimes taste, palpation's percussion - hands and fingers.

Auscultation - ears

Measurements such as height (length), weight, head circumference, vitals signs, and blood pressure are also essential components of every physical assessment.

1. Inspection

   a. involves the use of the sense, primarily vision, to make judgements, comparisons, decisions.

   b. requires skill, repetition, and practice to establish reliable findings for distinguishing among normal, borderline, and abnormal

   c. methods of inspection

      (1) conscious, systematic, and active use of one's senses

      (2) examine each body part, the visible areas are deliberately inspected for color, texture, firmness, hygiene, masses, hair distribution, tone, movement, behavior, tension, flaccidity, symmetry, location, position, temperature, and so on.

(3) during observation compare what constitutes normal anatomy and physiology

(4) consciously analyze behaviors, such as appearance, movement, relationships, activity, verbal interaction, mood, and orientation and to record what is observed

2. Palpation

a. palpation uses touch or the tactile sense to detect both superficial and deeper characteristics of the body

b. combined with inspection to validate a visual impression, such as texture of the skin

c. it is used to examine all accessible parts of the body, such as organs, glands, blood vessels, bones, muscles, hair, skin, and mucosa

(1) methods of palpation:

(a) neck for lymph glands or infants skull for fontanels: fingertips
temperature: tips of fingers and back or hand.
(b) vibration: such as heart thrills: palm of the hand
(c) consistency, position, size: grasping action
(d) deeper organs of the abdomen: liver, spleen, kidneys: bimanual maneuver

Note: For any type of palpation to be effective, especially for deep palpation of internal organs, the child must be relaxed. Position the child comfortably, for example, in a semireclining position in the parent's lap warming the hands before touching him, and distracting the child.

3. Percussion

   a. striking or tapping of the body surface to produce sounds that correlate with the type of underlying tissue density
   b. Table 2. definition of percussion sounds
   c. methods of percussion

      (1) direct - striking or tapping the body surface directly with the finger, useful for percussing well-defined areas, such as, bone or borders of organs.
      (2) indirect - tapping is done by striking a stationary finger positioned on the body

4. Auscultation

   a. evaluation of body sounds
   b. characteristics of auscultatory are the same as those used to describe percussion tones. (see table 2)
   c. methods of auscultation

      (1) direct: ear is applied directly to the body surface
      (2) indirect: use of a stethoscope to transmit internal body sounds to the nurse's ear.

         Two types of stethoscopes:

         (a) open-bell: low pitched sounds such as diastolic murmurs. need an airtight seal
         (b) closed diaphragm: more sensitive to high-pitched sounds airtight seal not needed

C. Pediatric Physical Exam

General Outline for assessment

1. General

a. measurements - table 3 General trends in physical growth during childhood.

(1) height
(2) weight
(3) head circumference
(4) vital signs
(5) blood pressure

b. general appearance - the general appearance of the child is a cumulative, subjective impression of the child's physical appearance, state of nutrition, behavior, personality, interactions with parents, nurse, and siblings, posture, development and speech

(1) physical appearance: facial, posture, hygiene

(2) nutrition: well - nourished or undernourished musculature, subcutaneous fat

(3) behavior: includes the child's personality, level of activity, reaction to stress, request, or frustration, interactions with others, degree of alertness, and response to stimuli

(4) development: overall estimation of the child's speech development, motor skills, degree of coordination, and recent area of achievement. Document with DDST (Denver Developmental Screening Test) if appropriate.

c. skin - assessed for color, texture, temperature, moisture and turgor. Hair is also inspected for color, texture, quality distribution, and elasticity

(1) variations in skin color:

(a) pallor and cyanosis
(b) erythema
(c) ecchymosis and petechiae
(d) jaundice

(2) texture

(a) moisture and temperature
(b) marks or scars
(c) common childhood problems:

i) cradle cap (scaliness on the scalp)
ii) eczema (scaliness and desquamation of the scalp, cheeks, knees, elbows)
iii) diaper rash
iv) excessive dryness

(3) temperature
(4) turgor

(a) tissue turgor refers to the amount of elasticity in the skin
(b) grasp between the thumb and index finger and quickly release it.
(e) normal tissue = resumes normal position poor skin turgor ="tenting"
(d) edema - swelling or puffiness

(5) accessory organs of the skin

(a) hair
(b) fingernails

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d. lymph glands

(1) assessed when the part of the body in which they are located is examined
(2) usual sites for palpating accessible lymph nodes are shown in Table 4
(3) major function: collect and filter the lymph of bacteria and other foreign matter as it returns to the circulatory system

2. Head

a. shape and symmetry

b. head control

c. scalp - cleanliness, lesions, scaliness signs of trauma; ecchymosis, masses of scars

d. skull - palpate patent sutures, fontanels, fractures, swelling

e. face - symmetry, movement, general appearance. Look for unusual swelling

f. sinuses - palpate and percuss for tenderness or swelling

3. Neck

a. range of motion
b. size and palpate it for associated structures
c. trachea
d. thyroid gland
e. cervical nodes

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4. Eyes - size, symmetry, color, motility and inspection of the interior surfaces for examination of retinal structures. Funduscopic examination - ophthalmoscope

   a. general inspection

   b. placement and alignment

      (1) relative placement on the face
      (2) symmetry of location
      (3) general slant of the palpebral fissures of the lids

   c. inspection of external structures

      (1) lids - color, size, mobility palpebralconjunctiva (lining of the lids)
      (2) eyelashes
      (3) bulbar conjunctiva
      (4) sclera
      (5) cornea
      (6) pupils

   d. internal structures

      (1) manipulating the ophthalmoscope
      (2) preparing the child
      (3) fundoscopic examination

         (a) red reflex
         (b) optic disc
         (c) blood vessels
         (d) macula

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5. Ears

   a. general inspection, placement and alignment

   b. inspection of external structures,

      (1) pinna - landmarks
      (2) skin surface
      (3) general hygiene
      (4) discharge from aural canal

   c. inspection of internal structure

      (1) use of the otoscope
      (2) positioning the child
      (3) entering the canal, positioning the otoscope
      (4) light reflex
      (5) bony landmarks
      (6) tympanometer

6. Nose

   a. inspection of external structures

      (1) placement and alignment
      (2) symmetry
      (3) signs of flaring

   b. inspection of internal structures

      (1) color of mucosal lining, as well as swelling, discharge, dryness or bleeding
      (2) inspect turbinates, septum
      (3) sense of smell

7. Mouth and throat

   a. lips - lesions

   b. internal structures

      (1) oral cavity:

         (a) mucous membranes
         (b) odor of breath
         (c) teeth
         (d) gums
         (e) tongue
         (f) hard palate
         (g) soft palate
         (h) uvula

      (2) oropharynx

         (a) tonsils
         (b) posterior pharynx

8. Chest

   a. size, shape, symmetry, movement breast development, presence of bony landmarks
   b. rib cage
   c. sternum
   d. thoracic cavity

      (1) size
      (2) shape
      (3) angle
      (4) symmetry
      (5) movement
      (6) nipples - breast development

9. Lungs

a. lobes - location

b. inspection:

(1) respirations

(a) rate
(b) rhythm
(c) depth
(d) quality
(e) character of breath sounds

(2) patterns of respiration (Table 5)

c. palpation:

(1) vocal fremitus
(2) crepitation

d. percussion:

e. auscultation

(1) vesicular breath sounds
(2) bronchovesicular breath sounds
(3) bronchial breath sounds
(4) absent or diminished breath sounds
(5) voice sounds

(a) whispered pectoriloquy
(b) bronchophony
(c) egophony

(6) adventitious sounds

(a) rales
i) fine, medium, coarse

(b) rhonchi
i) sibilant, sonorous

(c) pleural friction rub

10. Heart

a. overall assessment - comprehensive evaluation of pulse, blood pressure, respiratory function, and general physical growth and development

b. inspection - bulging, location of apical pulse

c. palpation - feel the point of maximum impulse, apex, thrills, pericardial friction rubs

d. percussion - outline borders

e. auscultation - origin of heart sounds

f. differentiating normal heart sounds

(1) quality
(2) intensity
(3) rate
(4) rhythm

g. various patterns of heart rate Table 6

h. grading of the intensity of heart murmurs

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11. Abdomen

a. inspection

(1) contour
(2) size and tone
(3) skin
(4) movement
(5) pulsation
(6) umbilicus
(7) hernia
(8) anal region

(a) fissures
(b) prolapse
(c) polyps
(d) skin tags

b. auscultation: peristalsis or bowel sounds

c. percussion: liver, stomach "gas bubble", shifting dullness

d. palpation

(1) superficial

(a) tenderness, muscle tone, superficial lesions, skin turgor
(b) tenderness

i) visceral
ii) somatic
iii) rebound tenderness

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(c) deep palpation - palpating organs and large vessels, detecting masses and tenderness

i) liver
ii) spleen
iii) kidneys
iv) bladder
v) cecum
vi) sigmoid
vii) aorta
viii) femoral pulses
ix) abdominal reflexes

12. Genitalia

a. male genitalia

(1) inspection - size of penis, glans and shaft prepuce, urethral meatus, size of scrotum, skin of scrotum, hair distribution

(2) palpation - identify: testes, epididymis, spermatic cords, and if present inguinal hernias

b. female genitalia

(1) inspection and palpation

(a) vulva or pudendum
(b) hair distribution
(c) clitoris
(d) labia majora
(e) labia minora
(f) urethral meatus
(g) vaginal orifice
(h) hymen
(i) bartholin's glands

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13. Back and Extremities

a. spine: posture - curvature; lordosis, kyphosis, scoliosis

b. back: tufts of hair, dimples, discoloration, masses, mobility

c. extremities: symmetry of length and size, count fingers/toes for evidence of clubbing, cyanosis, disorders of the nails and hygiene

d. arms and legs

(1) inspected for temperature, color, tenderness, and masses

(2) 5 main criteria:

(a) pain
(b) pulse
(c) paresthesia - abnormal sensation, ie. numbness
(d) pallor
(e) paralysis

(3) shape of bones is accessed: "bowleg" or genu varum, "knock knee" or genu valgum, tibial torsion

e. feet

(1) plantar reflex

(2) Babinski's sign - dorsi flexion of the big toe and fanning of the other toes, is normal during infancy but abnormal after one year of age or when locomotion begins

(3) gait

(a) metatarsus varus
(b) internal tibial torsion
(c) anteversion (forward turning) of the neck of the femur
(d) persistence of broad-based gait - may indicate problems with balancing in the cerebellum
(e) scissor gait - (spastic type cerebral palsy)
(f) waddling gait - child with a dislocated hip

(4) joints

(a) evaluate for range of motion (ROM)
(b) palpate for heat, tenderness, or swelling

(5) muscles

(a) development
i) shape and contour - in a relaxed and tense state

(b) tone
i) atrophy
ii) hypertrophy

(c) strength
i) push or pull against resistance

14. Neurologic assessment

a. behavior

(1) overall impression of the child's personality, affect, level of activity, social interaction, and attention span

(2) state - (level) of consciousness

(a) hyperirritability
(b) hyperactivity
(c) lethargy
(d) delirium
(e) stupor
(f) coma

Evaluate Level of Consciousness by observing the child's response to commands - calling his name or detecting his response to a pinprick or other painful stimuli

b. cognitive - perceptual development, best assessed using a formal screening test such as the DDST

c. motor functioning

(1) motor ability primarily involves assessment of voluntary muscle contraction and acquisition of age - specific developmental milestones for gross and fine motor skills

(2) muscle development - assess size, tone, strength, and abnormal involuntary

(3) other signs of possible neurologic damage

(a) hypeflexibility
(b) rapid blinking
(c) head nodding
(d) constant holding of both hands over the mouth
(e) markedly asymmetric or flaccid posture in an infant

d. sensory functioning

(1) assessed in terms of the sensory cranial nerves - vision, hearing, peripheral sensation

(2) tactile sensory intactness
(3) sensory discrimination
(4) hearing tests

(a) audiometry
(b) acoustic impedance or tympanometry
(c) startle reflex
(d) localization of sound
(e) five - toy test
(f) Rinne test - air conduction
(g) Weber's test - bone conduction

(5) vision testing

(a) light perception
(b) visual acuity: Snellen E chart
(c) (Denver Eye Screening Test) DEST

(d) peripheral vision or visual field
(e) color vision

i) Ishihara's test
ii) Hardy-Rand-Rittler (HRR)

e. cerebellar functioning

(1) cerebellum mainly controls balance and coordination

(2) much of the assessment of cerebellar functioning is included in observing the child's posture, body movements, gait and development of fine and gross motor skills

(3) tests for cerebellar function that can be performed as games include

(a) finger-to-nose test
(b) heel-to shin
(c) Romberg test

(4) coordination can be assessed by any sequence of rapid successive movements

f. reflexes:

(1) testing reflexes is an important part of the neurologic exam

(2) persistence of primitive reflexes, loss of reflexes or hyperactivity of deep tendon reflexes is usually the result of a cerebral insult

(3) superficial reflexes: abdominal, cremasteric, anal, and plantar

(4) Deep tendon reflexes: (DTR's)

(5) symptoms suggestive of meningitis use

(a) Kernigs sign
(b) Brudzinskis sign

g. cranial nerves - Table 4

h. "soft" signs:

(1) "a finding that is normal in a young child but that in the normal course of maturation should go away.... it represents a developmental delay or lag in the differentiation of a sensory of motor system"

(2) list of soft signs:

(a) short attention span
(b) unusual body movements, such as mirroring poor coordination and sense of position

(c) excessive, sustained, and purpose less movement (hyperactivity)

(d) hypeactivity
(e) impulsiveness
(f) labile emotions
(g) distractibility
(h) no established handedness
(i) language and articulation problems
(j) perceptual deficiets (space, form movement, and time)
(k) problems with learning, especially reading, writing, and arithmetic

Table 1.

AGE-SPECIFIC GUIDELINES FOR PHYSICAL EXAMINATION DURING CHILDHOOD

AGE	POSITION	SEQUENCE	PREPARATION
Infant	Before sits alone: supine or prone, preferably in parent's lap; before 4 to 6 months: can place on examining table After sits alone: use sitting in parent's lap whenever possible If on table, place with parent in full view	If quiet auscultate heart, lungs, abdomen. Record heart and respiratory Palpate and percuss same areas Proceed in usual head-toe direction. Perform traumatic procedures last (eyes, ears, mouth {while crying}) rectal temperature {if taken} Elicit reflexes as body part examined Elicit Moro reflex last	Completely undress if room temperature permits, Leave diaper on male Gain cooperation with distraction, bright objects, rattles talking. Smile at infant; use soft, gentle voice Pacify with bottle of sugar water or feeding Enlist parent's aid for restraining to examine ears, mouth Avoid abrupt, jerky movements

Table 1. (continued) AGE-SPECIFIC GUIDELINES FOR PHYSICAL EXAMINATION DURING CHILDHOOD

AGE	POSITION	SEQUENCE	PREPARATION
Toddler	Sitting or standing on/by parent Prone or supine in parent's lap	Inspect body area through play: "count fingers," "tickle toes" Use minimal physical contact Introduce equipment slowly Auscultate, percuss, palpate whenever quiet Perform traumatic procedures last (same as for infant)	Have parent remove outer clothing Remove underwear as body part examined Allow to inspect equipment: demonstrating use of equipment usually ineffective If uncooperative, perform procedures quickly Use restraint when appropriate; request parent's assistance Talk about examination if cooperative; use short phrases Praise for cooperative behavior

Table 1. (continued) AGE-SPECIFIC GUIDELINES FOR PHYSICAL EXAMINATION DURING CHILDHOOD

AGE	POSITION	SEQUENCE	PREPARATION
Preschool child	Prefer standing or sitting Usually cooperative prone/supine Prefer parent's closeness	If cooperative, proceed in head/toe direction If uncooperative, proceed as with toddler	Request self-undressing Allow to wear underpants if shy. Offer equipment for inspection: Briefly demonstrate use (may demonstrate on parent) Make up "story" about "I am going to give your arm a hug with this special cloth" (blood pressure) Use paper-doll technique Give choices when possible Expect cooperation; use positive statements. "Open your mouth"

Table 1. (continued) AGE-SPECIFIC GUIDELINES FOR PHYSICAL EXAMINATION DURING CHILDHOOD

AGE	POSITION	SEQUENCE	PREPARATION
School-age Child	Prefer sitting Cooperative in most positions Younger age prefer parent's presence Older age may prefer privacy	Proceed in head-toe direction May examine genitalia last in older child Respect need for privacy	Request self-undressing Allow to wear underpants Explain purpose of equipment and significance of procedure such as otoscope to see eardrum, which is necessary for hearing Teach about body functioning and care

Table 1. (continued) AGE-SPECIFIC GUIDELINES FOR PHYSICAL EXAMINATION DURING CHILDHOOD

AGE	POSITION	SEQUENCE	PREPARATION
Adolescent	Same as for school-age child Offer option of parent's presence	Same as older school-age child	Allow to undress in privacy Give gown Expose only area to be examined Respect need for privacy Explain findings during examination: "Your muscles are firm and strong" Matter of factly comment about sexual development: "Your breasts are developing as they should be" Emphasize normalcy of development. Examine genitalia as any other body part: may leave to end. May use mirror during examination of genitalia to allow youngster to view area examined and learn about personal anatomy

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Table 2. Definition of percussion sounds

Percussion sounds	Examples
TONES*	
Intensity - amplitude or loudness of tone	Loud tones - produced by more hollow, air-filled spaces, such as the lungs Soft tones - produced by more dense or solid masses, such as the heart
Pitch - frequency or number of vibrations per second; the greater the number of vibrations, the higher the pitch; the fewer the number, the lower the pitch	Low-pitched - air-filled lungs High-pitched - consolidated lung
Duration - time period of vibrations and length of time the	Long duration - normal lungs sound lasts Short duration - high-density organ, such as the heart
Quality or timbre - subjective evaluation that depends on the source of the sound	The same musical note from two different instruments produces a different quality or timbre of sound, for example, sounds of equal loudness and pitch from different organs, such as the lungs and heart, produce sounds of varying quality
NOTES	
Resonance - clear hollow note, low pitch, long duration, relatively loud (heard with ease)	Normal lungs
Tympany - clear hollow note, higher pitched than resonance, musical with rich overtones (quality), long duration	Tympanic sound can be produced by lightly tapping an air-filled cheek with the finger, similar sound when percussing an air filled stomach

Table 2. Continued

Percussion sounds	Examples
Hyperresonance - cross between resonance and tympany; lower pitch than normal resonance, high intensity, and long duration	Usually indicates less density, such as increased amount air or decreased amount of tissue; usually pathologic, such as pneumothorax or asthma
Dullness - high-pitched, short duration, soft (low intensity), and thudding	Related to increased density and solidarity, such as the heart
Flatness - absolute dullness, high-pitched, very short, non-muscial in quality	Solid tissue, such as the thigh

Adapted from Sana, J. M., and Judge, R. D.; Physical appraisal methods in nursing practice, Boston, 1975, Little, Brown and Co.
* These same terms are used to describe any sound and are used in physical assessment to record auscultatory sounds.

Table 3. General trends in physical growth during childhood

Age	Weight*	Height*
Infants Birth - 6 months	Weekly gain: 140-200 g (5-7 ounces) Birth weight doubles by end of first 6 months†	Monthly gain: 2.5 cm (1 inch)
6-12 months	Weekly gain: 85-140 g (3-5 ounces) Birth weight triples by end of first year	Monthly gain: 1.25 cm (0.5 inch) Birth length increases by approximately 50% by end of first year
Toddlers	Birth weight quadruples by age 2½ years	Height at 2 years is approximately 50% of eventual adult height Gain during second year: about 12 cm (4.8 inches) Gain during third year: about 6-8
Preschoolers	Yearly gain: 2-3 kg (4.4 - 6.6 pounds)	Birth length doubles by 4 years of age Yearly gain: 6-8 cm (2.4 - 3.2 inches)
School-age children	Yearly gain: 2-3 kg (4.4 - 6.6 pounds)	Yearly gain after age 7 years: 5.0 cm (2 inches) Birth length triples by about 13 years of age
Pubertal growth spurt Females - between 10-14 years	Weight gain: 7-25 kg (15-55 pounds Mean: 17.5 kg (38.1 pounds)	Height gain: 5-25 cm (2-10 inches): approximately 95% of mature height achieved by onset of menarche or sketetal age of 13 years Mean: 20.5 cm (8.2 inches)

Table 3. Continued

Age	Weight*	Height*
Males - between 11 - 16 years	Weight gain: 7-30 kg (15-65 pounds) Mean: 23.7 kg (52.1 pounds)	Height gain: 10-30 cm (4-12 inches); approximately 95% of mature height achieved by skeletal age of 15 years Mean: 27.5 cm (11 inches)

*Yearly height and weight gains for each age-group represent averaged estimates from a variety of sources.
†A recent study has shown the mean time for doubling of birth weight to be 3.8 months.

Table 4. Assessment of cranial nerves

Nerve	Distribution	Test
I - Olfactory (S)*	Olfactory mucosa of nasal cavity	With his eyes closed, have child identify odors such as coffee, alcohol from a swab, or other smells. Test each nostril seperately
II - Optic (S)	Rods and cones of retina, optic nerve	Check for perception of light visual acuity, peripheral vision, and normal optic disc.
III - Oculomotor (M)*	Muscles of eye	Have child follow an object such as a light or bright toy in all directions using only his eyes, not head movement.
IV - Trochlear (M)	Superior oblique muscle	Have child look downward.
V - Trigeminal (M, S)	Muscles of mastication, skin of face, and two thirds of anterior scalp	Have child bite down hard and open his jaw; test symmetry strength. With his eyes closed, see if child can detect light touch in the mandiblular and maxillary regions. Test corneal and blink reflex by touching cornea lightly (approach child from the side so that he does not blink before cornea is touched.)
VI - Abducens (M)	Lateral rectus muscle of eye	Have child look toward each side.
VII - Facial (M, S)	Nasal cavity and lacrimal gland, sublingual and submandibular salivary glands, muscles for facial expression, and anterior two thirds of tongue (taste)	Have child smile, make a funny face, or show his teeth to see symmetry of expression. Have child identify a sweet, sour, bitter solution. Place each taste on anterior section and sides of protruding tongue; if child retracts tongue, solution will dissolve toward posterior part of tongue.

Table 4. Continued

Nerve	Distribution	Test
VIII - Auditory, acoustic, or vestibulocochlear (S)	Internal ear	Test hearing; note any loss of equilibrium or presence of vertigo
IX - Glossopharyngeal (M, S)	Pharynx, tongue, and posterior one third of tongue for taste	Stimulate the posterior pharynx with a tongue blade; the child should gag. Test sense of taste on posterior segment of tongue
X - Vagus (M, S)	Muscles of larynx, pharynx, some organs of gastrointestinal system, sensory fibers of root of tongue, heart, lung and some organs of gastrointestinal system	Note hoarseness of the voice, gag reflex, and ability to swallow. Check that uvula is in midline; when stimulated with a tongue blade, should deviate upward and to the stimulated side.
XI - Accessory (M)	Sternocleidomastoid and trapezius muscles of shoulder	Have child shrug his shoulders while applying mild pressure. With the hands placed on his shoulders, have child turn his head against opposing pressure on either side. Note symmetry and strength.
XII - Hypoglossal (M)	Muscles of tongue	Have child move tongue in all directions. Have him protrude tongue as far as possible; note any midline deviation. Test strength by placing tongue blade on one side of tongue and having child move it away.

*S - sensory; M - motor

Table 5. Various patterns of respiration

Term	Description
Tachypnea	Increased rate
Bradypnea	Decreased rate
Dyspnea	Distress during breathing
Apnea	Cessation of breathing
Hyperpnea	Increased depth
Hypoventilation	Decreased depth (shallow) and irregular rhythm
Hyperventilation	Increased rate and depth
Kussmaul breathing	Hyperventilation, gasping and labored respiration, usually seen in diabetic coma or other states of respiratory acidosis
Cheyne-Stokes	Gradually increasing rate and depth with periods of apnea
Biot's breathing	Periods of hyperpnea alternating with apnea
Seesaw (paradoxical) respirations	Chest rises while the abdomen falls

Table 6. Various patterns of heart rate or pulse

Term	Description
Tachycardia	Increased rate
Bradycardia	Decreased rate
Pulsus alternans	Strong beat followed by weak beat
Pulsus bigeminus	Coupled rhythm in which beat is felt in pairs because of premature beat
Pulsus paradoxus	Intensity or force of pulse decreases with inspiration
Sinus arrhythmia	Rate increases with inspiration, decreases
Water - hammer or Corrigan's pulse	Especially forceful beat caused by a very wide pulse pressure (systolic blood pressure minus diastolic blood pressure)
Dicrotic pulse	Double radial pulse for every apical
Thready pulse	Rapid, weak pulse that seems to appear and disappear

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PEDIATRIC MALIGNANCY: AN OVERVIEW

Pamela L. Cummings R.N., B.S.N.

I. Scope of the problem

A. Incidence

B. Mortality

C. Prognosis

D. Comparison with adult cancers

II. Approach to care

A. Multidisciplinary team

B. Family centered care

III. Epidemiology

A. Environmental factors

B. Host factors

C. Genetic factors

D. "Two hit" theory

IV. Forms of Childhood Cancer

A. Leukemia

1. ALL (Acute Lymphocytic Leukemia)

a. Clinical presentation

b. Diagnosis

c. Treatment

d. Prognosis

2. ANLL (Acute Non-Lymphocytic Leukemia)

a. Clinical presentation

b. Diagnosis

c. Treatment

d. Prognosis

B. Central Nervous System (Brain Tumors)

1. Clinical presentation

2. Diagnosis

3. Treatment

4. Prognosis

C. Lymphomas

1. Hodgkins

a. Clinical presentation

b. Diagnosis

c. Treatment

d. Prognosis

2. Non-Hodgkins

a. Clinical presentation

b. Diagnosis

c. Treatment

d. Prognosis

D. Neuroblastoma

1. Clinical presentation

2. Diagnosis

3. Treatment

4. Prognosis

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E. Wilm's Tumor

1. Clinical presentation

2. Diagnosis

3. Treatment

4. Prognosis

F. Rhabdomyosarcoma

1. Clinical presentation

2. Diagnosis

3. Treatment

4. Prognosis

G. Bone Tumors

1. Ewings Sarcoma

a. Clinical presentation

b. Diagnosis

c. Treatment

d. Prognosis

2. Osteogenic Sarcoma

a. Clinical presentation

b. Diagnosis

c. Treatment

d. Prognosis

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H. Retinoblastoma

1. Clinical presentation

2. Diagnosis

3. Treatment

4. Prognosis

V. Factors Contributing to Improved Prognosis

A. Combination Therapy

B. Multidisciplinary approach

C. Participation in national studies

D. Supportive Care

1. Blood component therapy
2. Anti-emetic regimen(s)
3. Infectious disease
4. Improved delivery of care
    a. venous access devices
    b. community health care
    c. home health nursing
    d. community physician
    e. hospice

PEDIATRIC ONCOLOGY OVERVIEW
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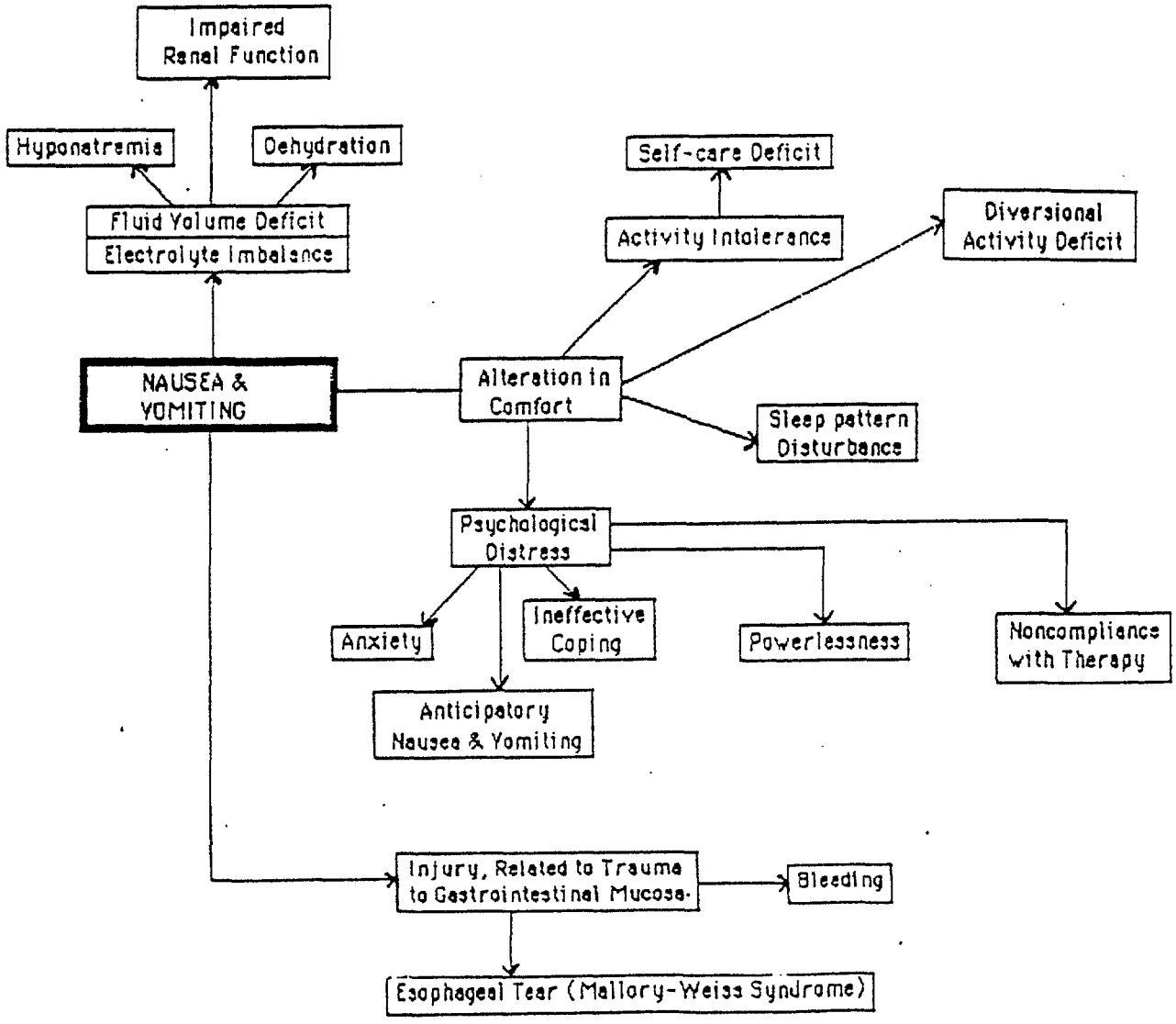
ANTIEMETICS AND CANCER CHEMOTHERAPY

LaVonne Ridder R.N., M.A.

Nausea is common following chemotherapy and can be acute (during or immediately following administration), subacute (6-12 hours later), delayed (2-3 days later) or anticipatory (conditioned response to past experience of nausea or vomiting after chemotherapy administration). It is important to attend to nausea and vomiting control because of complications which could occur as a side effect. Complications could include esophageal tears, fractures, prolonged anorexia, malnutrition, metabolic abnormalities, and volume depletion.

POTENTIAL PATIENT PROBLEMS



[Borrowed from Barton-Burke, (1991) Cancer Chemotherapy: A Nursing Process Approach. Boston:Jones and Bartlett Publishers,p. 92]

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Definitions:

Nausea: vague wavelike sensation and conscious need to vomit

Vomiting: actual forceful expulsion of gastric contents through the mouth

Retching: rhythmic contraction of respiratory muscle causing up and down movement of gastric contents into the esophagus

Physiology of Nausea and Vomiting:

1. The vomiting center is located close to the reflex centers controlling cardiovascular and respiratory function causing:

    a. tachycardia

    b. diaphoresis

    c. weakness/dizziness + nausea

    d. bradycardia

    e. decreased blood pressure during vomiting

    f. increased rate and depth of respiration

2. The vomiting center receives stimulation from:

    a. intestinal tract through the vagus nerve stimulated by delayed gastric emptying or GI distension

    b. cortical pathway via hypothalamus, stimulated by anxiety or increased intracranial pressure (probable cause for anticipatory nausea and vomiting)

    c. vestibular pathway via labyrinth system and vagus nerve, stimulated by rapid position changes (does not play a significant role in chemotherapy induced emesis)

d. peripheral pathways via sympathetic visceral afferent from the GI tract, heart and kidneys. Stimulated by irritation or spasm

e. chemoreceptor trigger zone (CTZ stimulated by blood borne toxins, drugs such chemotherapy, and altered hormones of pregnancy (the chemoreceptor trigger zone contains receptors for histamine, dopamine, acetylcholine and opiated) -- but the actual neurochemical physiology of chemotherapy induced nausea and vomiting is not well known

Principles of antiemetic administration:

1. Give the antiemetic that works best for the particular situation, particular patient and cause.

2. The most effective antiemetic regimens include drugs that act on some or all of the different pathways.

3. Although it is probable that nausea and vomiting occurring after chemotherapy administration is related to the drugs given, it is important to exclude other causes (bowel obstruction, peritonitis, CNS metastasis, drugs such as narcotics, fluid and electrolyte balance, hepatic metastasis, infection, radiation therapy and uremia)

4. Consider psychogenic factors and attempt to prevent with first cycle (hypnosis with guided imagery, systematic desensitization, progressive muscle relaxation)

5. The degree of nausea and vomiting and duration of distress may be related to the chemotherapy drug, dose, frequency, method of administration, and delayed excretion of the drug or drug metabolites.

6. Conduct a prechemotherapy assessment which should include hydration and electrolyte status (correct if not right) and anxiety status (give support and empathy as appropriate).

7. Administer antiemetics to cover the duration of action for the period of expected nausea and vomiting from the specific chemotherapy agent

Antiemetic Treatment:

1. Start antiemetics prior to chemotherapy so that receptors in the CTZ can be efficiently blocked, thereby preventing the nausea and vomiting by building up blood levels of the antiemetic.

2. Schedule according to route of administration

3. Administer regularly for 24 hours so drugs can maintain a moderate to high antiemetic effect.

EMETIC POTENTIAL OF CHEMOTHERAPY DRUGS

HIGH (> 80% INCIDENCE)	ANTIEMETIC REGIMEN
mechlorethamine (nitrogen mustard) decarbazine (DTC) cisplatin (platinol) Mitomycin C BCNU, CCNU high dose cyclophosphamide high dose methotrexate high dose cytosine arabinoside	Aggressive combination antiemetics, high dose phenothiazine or odansetron, with dexamethasone; lorazepam; or THC

MODERATE (50% INCIDENCE)	
doxorubicin (Adriamycin) daunorubicin (Daunomycin) cyclophosphamide (Cytoxan) ifosfamide dactinomycin (Actinomycin D) mitoxantrone procarbizine etoposide hexamethylmamine	Moderately aggressive therapy with intravenous odnasetron, phenothiazine

LOW (< 25% INCIDENCE)		
5-fluorouracil (5-FU) methotrexate bleomycin cytosine arabinoside (Ara-C) melphalan vincristine hydroxyurea etoposide	thiopeta thioguanine tamoxifen chlorambucil L-asparaginase vinblastine teniposide 6-mercaptopurine	Phenothiazines and odnasetron

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INFECTION IN PATIENT UNDERGOING CANCER TREATMENT

Tribhawan S. Vats, M.D.
Pamela L. Cummings R.N., B.S.N.

I. Essentials of Cancer Therapy

   A. Medical Treatment

   B. Supportive Care

II. Cause of Infection

   A. Underlying Disease Itself

   B. Treatment of Disease

   C. Both Alter Host Defenses

III. Compromised Host

   A. Invasion of skin and mucosal barrier

   B. Phagocute defense

      1. Neutrophils

      2. Monocytes

         a. Macrophages

   C. Alteration of cellular and humoral immunity

   D. Splenectomy

   E. Altered nutritional status

F. Acquisition and colonization of microbial flora

G. Intensity of treatment regimen

IV. Fever and Neutropenia

A. 3 Readings of 38°C in 24 hours

B. Single spike of 38.5°C

C. ANC of L 1000/mm^3 and sick patient

D. ANC of L 500/mm^3 - isolation precautions

E. Absolute Neutrophil Count

F. ANC Calculation:

V. Compromised Host with Fever

A. Assessment of Neutrophil Count

B. Type of infection and identification of infectious agent

C. Host susceptibility

D. Diagnostic evaluation

E. Empiric antibiotic - cephalosporin + aminoglycoside

VI. Evaluation of febrile neutropenic patient

A. History and thorough physical examination

B. Two sets of blood cultures for bacteria and fungi

C. Cultures from central line if present

D. Cultures from anterior nares, throat, and urine

E. Stool cultures for bacterial, viral fungal and clostridium agents.

F. CXR

G. Sinus x-ray

H. CBC, serum transaminases, electrolytes, BUN and creatinine

I. Aspirate and biopsy from skin lesions if present

VII. Empiric Therapy

A. Monotherapy (Ceftazidine)

B. Combination antibiotics (Ceftazidine, Tobramycin)

C. Vancomycin added up front for indwelling catheter patients

VIII. Fever and neutropenia at 72 hours

A. <u>Causes</u>

1. Non-bacterial infection
2. Resistant bacteria
3. Super infection
4. Inadequate concentration of antibiotics
5. Rare organisms

B. <u>Assessment</u>

1. Repeat blood and port cultures
2. Repeat chest x-ray or sinus x-ray if indicated
3. Examine the port and surrounding area
4. Check all previous cultures
5. Clinical assessment of the patient

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IX. Treatment of Specific Infection

Bacterial Infection

A. Organisms

1. Gram negative E.C.
2. Pseudomonas, Klebsiella, E. Coli
3. Gram positive E.C.
4. Staphylococcus epidermidis, and hemdytic strop and diptheriods

X. Standard antibiotic regimen

A. Tobramycin 7.5 mg/kg/day IV every 8 hours
B. Fortaz 150 mg/kg/day IV every 8 hours
C. Oxacillian 200 mg/kg/day IV every 8 hours
D. Clindamycin 40 mg/kg/day IV every 6 hours
E. Vancomycin 40 mg/kg/day IV every 6 hours

Always check peak and though levels to adjust dosage

XI. Prophylaxis of bacertial infections

A. Oral non absorbable antibiotics
B. Trimethoprim Sulfamethoxazole
C. Quinoline group of antibiotics

XII. Viral Infections

- Chicken-pox

- Herpes zoster

- Cytomegalovirus

- Epstein Barr Virus

A. Chicken-pox

1. Visceral dissemination occurs very commonly

2. Severe pneumonia encephalitis and hepatic damage can occur

3. More severe in patients on chemotherapy and having lymphopenia (L 560/mm_3)

B. Herpes Zoster (Shingles)

1. More morbidity than mortality

2. Involves several dermatomos

3. Neurologic involvement quite common

4. More common in patients with Hodgkins disease and lymphoma treatment with acyclovir

C. Cytomegalovinus

1. May be caused by blood transfusion organ transplantation or reactivation of latent virus

2. Diagnosed by increase in I gm immunofluorescent antibody titer

3. May cause multisystem disease

4. Treatment most successful with IV gammaglobulin and gancyclorir

XIII. Fungal Infections

A. Fungal Infections

1. Candida Albicans

2. Candida Glabrata

3. Aspergillosis

4. Crytococosis

5. Histoplasmosis

B. Fungal Infections

1. Treatment

a. Amphotericin B

(1) 0.2 mg/kg/day starting dose increase to 0.7 to 1.0 mg/kg/day

(2) total duration - 2-8 weeks

b. Prophylaxis

(1) Nystatin

(2) Ketaconezole

(3) Fluconozole

XIV. Other Infections

A. Pneumocstis Carinii Pneumonia

1. Usually appears in remission state
2. Sudden onset of respiratory difficulty
3. Tachypnea, ashen color
4. Multiple lobe infiltrate in lungs
5. Lungs usually without roles

B. Pneumocystis Carinii Pneumonitis

1. Diagnosis by lung biopsy, lung aspirate or clinical
2. Treatment with TMP - 2 mg/kg/day and SMZ 100 mg/kg/day divided every 6 hours IV
3. If no response use pentamidine 4 mg/kg/day. IV for 10-14 days.

XV. Protected Environments

A. Added Expense

B. Psychological Trauma

C. Benefits unproven

D. Best indication is protracted neutropenia

CHEMORADIOTHERAPY INDUCED STOMATITIS

PAMELA L. CUMMINGS R.N., B.S.N.

I. Introduction

A. Incidence

B. Definition

1. Stomatitis

2. Xerostomia

C. Causative Factors and their Sequelae

1. Radiation to head and neck (Table 7)

a. Salivary gland dysfunction

b. Increase of crown and root caries

c. Altered taste sensation

d. Intraoral hemorrhage

2. Stomatotoxic Chemotherapeutic Agents

a. Increase potential for systemic bacterial invasion

b. Increase oral discomfort

c. Decrease nutrition

d. Delay of therapy

II. Diagnosing the Problem

A. Physical Characteristics

B. Subjective Data

1. Oral perception guide (Table 7)

C. Objective Data

1. Oral Assessment guide (Table 7)

III. Treatment (Table 8)

A. Aimed at prevention

1. Prechemoradiotherapy guidelines

a. Referral to Dental/Oncology Program

b. Personal Oral hygiene

c. Establishment of oral health protocol (s)

B. Standard Treatment Regimens

1. Agents utilized to control pain

2. Topical application (s)

3. Antifungals

4. Agents to control intraoral hemorrhage

5. Agents utilized to treat xerostomia

TABLE 7. ORAL EXAMINATION GUIDE: AN ASSESSMENT GUIDE TO ORAL AND PHYSICAL CONDITIONS

	Numerical and descriptive ratings			
Category	1	2	3	4
Lips	Smooth, soft, moist to dry	Rough, dry, may be crusted	Rough, swollen, dry, may be blistered	Dry, cracked, bleeding or ulcerated
Mucous membranes palate, oropharynx	Pink, moist, no debris	Red, edematous, slightly dry, burning sensation	Red, dry, may be ulcerated or coated with debris	Very red or ulcerated, inflamed, probable debris
Gingivae	Pink, moist, no debris	Pale, slightly dry, may have reddened areas pustules	Red, shiny, edematous, ulcerated	Red, shiny, ulcerated, bleeds easily
Saliva	Thin and watery	Increased in amount	Scanty, mouth dry	Thick and ropy, viscid
Ability to swallow	Swallows/eats with no problem	Discomfort on swallowing/ eating	Pain on swallowing/ eating	Unable to swallow/eat
Diet	Normal in fluid and amount of chewing needed			
Self-care	Independent	Needs to be encouraged to eat and to do oral hygiene	Assistance needed to eat and to do oral hygiene	Totally dependent on others for eating and oral hygiene

Adapted from Beck, S. Impact of a systematic oral care protocol on stomatitis after chemotherapy. Cancer Nursing, 1979 2:192, and Ziga S. Stomatitis/mucositis. In Yasko J. Guidelines for cancer care symptom management. Reston, Virginia: Reston Publishing, 1983:216-7. Cancer Nursing, Vol. 10, No., 3, 1987

TABLE 7. (continued)

ORAL PERCEPTION GUIDE

	Numerical and descriptive ratings			
Category	1	2	3	4
Lips	My lips feel moist and comfortable	My lips feel slightly dry	My lips are dry and burn, especially at the corners	My lips burn intensely: they are cracked and it hurts to open my mouth
Gingivae	My guns feel moist and comfortable	My gums are a little sore but I am hardly aware of it	My gums are sore and it is annoying	My gums are so sore that I am constantly aware of pain
Saliva	My mouth feels moist	I feel like my saliva has increased	I feel like my saliva has decreased	My mouth is very dry and my saliva is thick
Taste	There is no change in my taste	Things taste slightly different	Nothing tastes right	I can't taste anything
Eating	I have no difficulty eating because of my mouth	It is harder to eat because my mouth is so dry	Certain foods, especially hot and spicy foods, burn my mouth	It hurts so much to chew and swallow that I can't eat

Adapted from Beck, S. Impact of a systematic oral care protocol on stomatitis after chemotherapy. Cancer Nurse 1979;2:192.

Table 8

FORMULARY OF TOPICAL MEDICATIONS FOR SPECIFIC ORAL PROBLEMS

PROBLEM	MEDICATION	USE
Localized secondary topical lip infection	Neosporin	Apply to perioral lesions 2-5 times daily depending on severity of lesions
Prevention of caries secondary to xerostomia	Acidulated fluoride rinse	Rinse daily for 1 min with 5 ml. to 10 ml.
		Do not swallow. Switch to neutral fluoride if aucositis present. *+
	Neutral fluoride rinse	Rinse daily for 1 min with 5 ml to 10 ml. Do not swallow. Switch back to acidulated fluoride rinse when mucous resolves.
ANTIFUNGAL AGENTS		
Prevention and treatment of oral candidiasis	Nystatin oral suspension	Rinse and swallow 300,000 unit 3-4 times daily. If intolerance to swallow rinse only.
	Clotrimazole troche 10	Dissolve 1 tablet 5 times daily. The prophylactic use of clotrimazole for the prevention of candidiasis has not been adequately studied.
Treatment of candidiasis under dentures or at corners of mouth	Mycolog ointment	Apply to affected area 2 to 3 times daily or place under denture surface
Palliation of mucositis	Xylocaine viscous 25% solution	15 ml swished for 30 sec maximum every 3 h. Expectorate.
	Dyclonine hydrochloride 0.5% or 1% solution	15 m. swished for 30 sec every 2 to 3 h. Expectorate.
	Benadryl and Kopectate mix solution of 50% each	Swish 15 ml for 30 sec every 2 to 3 h Expectorate.
Palliation of mucositis (localized)	Benzocaine in orabase ointment	Apply to affected dried area every 2 to 3 h. Not to be used in presence of infection.

Table 8 (continued)

PROBLEMS	MEDICATION	USE
CONTROL OF LOCAL BLEEDING		
Gingival	Topical thrombin solution	Apply to affected area with gauze sponge and hold in place with pressure for 30 min. Do not remove formed clots
Mucosal surface bleeding	Microfibrillar collagen	Apply to dried site with dry gauze sponge for 1 to 5 min. Do not use in closure of mucosal incisions.
XEROSTOMIA		
Saliva substitutes mouth moisturizers	Salivant synthetic saliva-spray	Spray as needed for mouth xerostomia
Saline may also be used	Xerolube	Rinse as needed for xerostomia.

*Fluoride gels in custom trays are preferred.
+Acidulated fluorides are contraindicated in patients with porcelain prostheses.

DeVita, Vincent T.; Hellmen, S; Rosenberg, SA: Cancer, Principles and Practice of Oncology. Philadelphia: Lippincott, 2 ed. Vol. 2, 1985: 2017-2018.

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VENOUS CATHETERS
Pamela L. Cummings R.N., B.S.N.

I. Overview of catheter types classified by anatomical location.

A. Venous catheters

1. Short-term venous catheters
2. Long-term venous catheters

B. Arterial catheters

C. Intraperitoneal catheters

D. Epidural catheters

II. Venous catheters

A. Types

1. Short-term venous catheters not tunneled SQ

a. Characteristics

(1) material
(2) small gauge (usually 15 gauge internal diameter) pediatric gauge / diameter 22 gauge
(3) sutured in place
(4) radiopaque

b. Percutaneous placement

(1) peripherally through the basilica vein in the antecubital fossa
(2) centrally through the subclavian or jugular veins
(3) other

2. Long-term venous catheters funneled SQ

a. characteristics

(1) material
(2) gauge

(a) smallest lumens
(b) largest lumens

(3) features

(a) single lumen
(b) double lumen
(c) triple lumen
(d) pediatric

(4) Dacron $_{TM}$ cuff

(a) allows embedding into the subcutaneous tissue
(b) allows stabilization of catheter
(c) minimizes risk of ascending infection

(5) Radiopaque

b. placement

(1) large vein

(a) cephalic
(b) internal jugular
(c) subclavian
(d) femoral

(2) with the tip resign just above the right atrium (if placed femorally, tip may not be in the right atrium)

(3) tunneled through the subcutaneous tissue to an exit site usually on the chest wall

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B. Clinical Indications

1. Short-term venous catheters

   a. short-term tx i chemotherapy (45-60 days)
   b. short-term infusions of vesicant chemotherapy
   c. inpatient or outpt-chemotherapy
   d. single bolus injections of chemotherapy
   e. brief life expectancy
   f. other

2. Long term venous catheters

   a. blood sampling
   b. bone marrow transplant
   c. leukemia patients
   d. short-term or long-term infusion of vesicant or non-vesicant chemotherapy
   e. inpatient or outpatient chemotherapy
   f. total parent nutrition (TPN)
   g. antibiotictherapy
   h. additional supportive therapies

C. Patient assessment / selection criteria

1. low-priority patients for venous catheters

   a. infrequent venous access
   b. short-term therapy
   c. intermittent single injections
   d. non-vesicant / non-irritating drugs
   e. no previous intravenous therapy
   f. adequate venous access
   g. patient does not want venous catheter
   h. other

2. high-priority patients for venous catheters

   a. limited venous access
   b. frequent venous access
   c. long-term indefinite treatment period
   d. continuous infusion chemotherapy
   e. home infusion of chemotherapy
   f. vesicant / irritating drugs
   g. patient with venous thrombosis / sclerosis from previous therapy
   h. patient's desire for venous catheter
   i. available care giver (patient or significant other)
   j. other

D. Principles of management

1. accessing the system

   a. aseptic technique
   b. clamping long-term catheters

2. maintaining patency of the system

   a. flushing
   b. positive pressure
   c. heparinization

3. exit site care

4. injection cap changes

E. Major complications

1. catheter damage

   a. assessment

   b. prevention

   c. treatment / intervention

2. loss of blood return

   a. assessment

   b. prevention

   c. treatment / intervention

3. occlusion

   a. assessment

   b. prevention

   c. treatment / intervention by following declotting procedure

4. infection

   a. assessment

   b. prevention

   c. treatment / intervention

5. dislodgement

   a. assessment

   b. prevention

   c. treatment (intervention by removal of catheter)

6. catheter migration

   a. assessment

   b. prevention

   c. treatment / intervention

7. venous thrombosis

   a. assessment

   b. prevention

   c. treatment / intervention

F. Patient Education

1. description of catheter
2. catheter uses
3. catheter insertion
4. care of exit site
5. flushing catheter and hepannization
6. changing injection cap
7. possible complication

    a. severance
    b. loss of blood return
    c. occlusion
    d. infection
    e. dislodgement
    f. catheter migration
    g. thrombosis

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PEDIATRIC ONCOLOGIC EMERGENCIES

Pamela L. Cummings R.N., B.S.N.

I. Types

A. Mechanical

B. Metabolic

II. Pediatric Oncologic Emergencies

A. Thoracic Emergencies

1. Superior Vena Cava Syndrome

2. Superior Mediastinal Syndrome

a. Etiology

b. Pathophysiology

c. Evaluation/Diagnosis

d. Therapy

B. Pleural and Pericardial Effusions

1. Definition

2. Evaluation

3. Therapy

C. Cardiac Tamporade

1. Definition

2. Etiology and Pathogenesis

3. Evaluation/Diagnosis

4. Therapy

D. Abdominal Emergencies

1. Definition

a. Esophagus

b. Stomach

c. Small intestine

d. Typhlitis

e. Perirectal Abscess

f. Cholecystis and Biliary Obstruction

g. Hemorrhagic Pancreatitis

E. Genitourinary Emergencies

1. Definition

2. Pathophysiology

3. Evaluation/Diagnosis

a. Hemorrhagic Cystitis

b. Urinary Flew Obstruction

F. Neurologic Emergencies

1. Definition

a. Acute Alterations in consciousness

(1) Etiology

(2) Pathophysiology

(3) Evaluation/Diagnosis

(4) Treatment

b. Cerebrovascular Accidents

(1) Etiology

(2) Pathophysiology

(3) Evaluation/Diagnosis

(4) Treatment

c. Seizures

(1) Etiology

(2) Pathophysiology

(3) Evaluation/Diagnosis

(4) Treatment

d. Spinal Cord Compression

(1) Etiology

(2) Pathophysiology

(3) Evaluation/Diagnosis

(4) Treatment

G. Hyperleukocytosis

1. Etiology

2. Pathophysiology

3. Evaluation/Diagnosis

4. Treatment

H. Metabolic Emergencies

1. Tumor Lysis Syndrome

   a. Etiology

   b. Pathophysiology

   c. Evaluation/Diagnosis

   d. Treatment

2. Hypercalcemia

   a. Etiology

   b. Pathophysiology

   c. Evaluation/Diagnosis

   d. Treatment

3. Syndrome of Inappropriate Antidiuretic Hormone (SIADH)

   a. Etiology

   b. Pathophysiology

   c. Evaluation/Diagnosis

   d. Treatment

RADIATION THERAPY

Pamela L. Cummings R.N., B.S.N.

Irradiation is frequently used in the treatment of childhood cancer, usually in conjunction with chemotherapy and/or surgery. It can be used for curative purposes and if often employed for palliation to relieve symptoms by shrinking the size of the tumor.

Recent advances in radiation therapy have optimized its beneficial effects and minimized many of the undesirable side effects.

I. Cytotoxic effect

A. Ionizing radiation is cytotoxic in at least three different ways

1. damaging the pyrimidine bases cytosine, thymine, and uracil needed for the synthesis of nucleicacids

2. causing single-strand breaks in the DNA or RNA MOLECULE

3. causing double helicalstrand breaks in these molecules these molecules

The effect of disturbing cellular metabolic and reproductive function is either sublethal or lethal damage.

Lethal damage - refers to the death of the cell

Sublethal damage - refers to injured cells that may subsequently be repaired

Many of the acute side effects are the result of lethal damage to radio - sensitive tissue, particularly proliferating cells such as those of the bone marrow, gastrointestinal tract, and hair follicles.

Late effects may be the result of cell death, such as infertility, or the consequences of sublethal damage, such as premature aging from a shortened cell life span.

Side effects:
Acute reactions - dependent on the area to be irradiated, total dose given, age of the child (the younger child the more radiosensitive his body organs), location of the tumor.

TBI - total body irradiation is associated with the most severe reactions

Summary of the acute and late effects of radiation therapy.

PAIN ASSESSMENT AND MANAGEMENT

Pamela L. Cummings R.N., B.S.N.

I. Assessment of pain

A. Knowledge of children's response to pain yields valuable data for an assessment plan

B. Basic assumptions regarding pain perception and expression are foundational:

1. pain is subjective, personal and not directly communicable

2. pain is integrally interwoven with emotions such as fear, anxiety, anger loneliness, or depression, and the emotion itself may <u>increase</u> the perception and expression of pain

3. the expression of pain varies with age

4. nonverbal communication, specifically a change in behavior, precedes verbal communication of pain

Two criteria for monitoring all ages of children:

* physiologic response - Heart Rate, Blood Pressure, Respiratory Rate

* behavioral response - observe cry characteristics and duration, visual tracking, body movement, response time to stimuli

C. Preverbal children - infants

1. express pain through behaviors such as:

   a. tense body posture
   b. irritability
   c. inability to be comforted by usual measurers
   d. rolling of the head
   e. flexing extremities
   f. rubbing or pulling on a body part
   g. lethargy
   h. overreaction to usual stimuli

Reaction to induced pain is primarily physical resistance.

D. Preschoolers:

1. exhibit pain primarily through behavior but begin to verbally communicate its location

2. psychosomatic pain and cultural expressions become evident, as well as an increased ability to control pain responses

3. self report scale: such as, nine face interval scale

E. Older children:

1. explicitly describe their pain but are also more sophisticated in hiding or exaggerating it for personal gain. However, subtle behaviors such as a strained facial expression, rigid positioning of a body part, or unusual quietness are clues to the presence of pain.

2. self report scale: Linear Analogue Scale

II. Pain Management Drugs:

A. Nonsteroidal anti-inflammatory drugs (NSAIDS)

1. Acetaminophen - 10-15mg/kg PO Q 4h

2. Aspirin (ASA) - 10-15mg/kg PO Q 4h

3. Ibuprofen (100mg/5ml) 3-8 mg/kg PO Q 4-8h
> 6 months

B. <u>Opiods</u>

given per cardiovascular monitoring guidelines

1. Morphine

a. 0.05 - 0.1 mg/kg N Q 2-4h

b. 0.02 - 0.05mg/kg/h cont.IV

c. 0.1 - 0.15mg/kg/M/SC Q 3-4h

d. 0.1 - 0.2 mg/kg PO Q 4-6h

2. Meperidine (Demerol)

   a. 0.8 - 1 mg/kg N Q 2h
   b. 0.8 - 1 mg/kg 1M/SC Q 3-4h

3. Codeine

   a. 0.5 - 1.2 mg/kg PO Q 4h

4. Oxycodone (Percodan)

5. Methadone: 0.1 - 0.2 mg/kg PO/IV q6-12h.

6. Levorphanol tartrate (Levo-Dromoran):

7. Hydromorphone (Dilaudid): 0.015-0.03 mg/kg IV/IM/SC q 3-4h

C. Pediatric Sedation

1. Contradictions to sedation:

   a. full stomach (solid foods 8 hrs, clear liquids 4-6 h)

   b. impaired respiratory status

   c. altered level of consciousness

   Give sedation per institution protocol guidelines.

2. Benzodiazepine

   a. causes: sedation, anxiolysis, amnesia. Decrease doses when used concurrently with opiates

   b. Diazepam (Valium)

      (1) 0.2 - 0.5 mg/kg/dose PO

      (2) 0.05 - 0.2 mg/kg/dose IV

      (3) IM ineffective, very painful

   c. Lorazepam (Ativan) - 0.05 mg/kg/dose IM/IV

   d. Midazolam (Versed) - max dose 2/mg 0.035 - 0.2 mg/kg/dose IM/IV 0.5 mg/kg PO, 0.5 - 0.1 mg/kg PR

3. Barbiturate - causes: sedation and sleep

   Pentobarbital (Nembutal) 2-4 mg/kg/dose PO, PR, IM max dose 120 mg

4. Narcotic: see Opiods section II - B causes: sedation and analgesia

5. Miscellaneous Drugs:

   a. chlorpromazine (thyroxine) 0.5 - 1.0mg/kg/dose 1M, IV max. dose 50 mg

   b. chloral hydrate - 25 - 100 mg/kg/dose PO, PR, max dose 2gm

   c. hydroxyzine (vistaril) - 0.5 - 1mg/kg/dose 1M

   d. promethazine (phenergan) 0.025 - 0.1 mg/kg/dose 1M/IV

6. Drug combinations

   a. PO

      (1) meperidine 1.5 mg/kg PO

      (2) diazepam 0.2 mg/kg PO

      (3) atropine 0.02 mg/kg PO

   b. PO

      (1) meperidine (demerol) 1.5 mg/kg PO

      (2) thorazine (chlorpromazine) 2.5-6 mg/kg/24h ÷ Q 4-6h

      (3) benadryle (diphenhydramine) 5mg/kg 24h ÷ Q 6h

c. DPT Cocktail (may mix in same syringe): max dose: 300 mg/24h

d. IM

(1) meperidine (demerol) 2mg/kg 1M

(2) promethazine (phenergan) 1mg/kg 1M

(3) chlorpromazine (thorazine) 1mg/kg 1M

CARDIOPULMONARY ASSESSMENT

I. Personnel

A. Practitioner performing the procedure for which sedation is needed

B. An assistant trained in basic life support who can administer arrest drugs and who is familiar with available emergency equipment

C. An assistant to help stabilize and monitor patient during the procedure

II. Assessment

A. During procedure

1. monitor vital signs including: BP, O_2 saturation using pulse oximeter, ECG if indicated, and physical examination

B. After procedure

1. monitor as above, make sure air way and arcuation are stable, patient is alert and can talk, and patient can sit unaided and ambulate without assistance

III. IV access

A. have available catheters in various size, fluid administration sets, and IV fluids (Ringer's lactate, D5W with salt).

Stable IV access is recommended when giving IV Valium, versid and Demerol

IV. Emergency cart

Make sure emergency cart is fully equipped with suction, oxygen and oxygen delivery system, and airway management equipment (oral airways, masks, laryngoscopies, blades, ET tubes, stylet)

V. Drugs

Have epinephrine, bicaborate, atropine, lidocaine, bretyllium, glucose, naloxone, and physostigmine available

Ref: American Academy of Pediatrics Committee on Drugs. Pediatrics 1985; 76: 317

COPING WITH CANCER

Lavonne Ridder R.N., M.A.

I. Cancer has powerful personal and cultural meanings. The person with cancer may reinterpret much of his or her past life in light of the cancer experience (Also true of the parent reminiscing about the pediatric cancer patient).

   A. Influence of personality, stress and lifestyle on causes of cancer

   B. Cultural meanings of cancer

      1. Death and suffering as taboo topics

      2. Evokes a sense of economic catastrophe

      3. Evokes a sense of terror and sense of betrayal

      4. Not a suitable topic for conversation

II. "Hoping is Coping"

   A. The role of personal history

   B. The role of the situation

   C. Prediagnostic phase

D. Diagnostic phase

E. Treatment phase

F. Remission

G. Recurrence

H. Death and Dying

1. "Healthy Dying" movement
2. Death lacks meaning.
3. Ways of understanding

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LATE EFFECTS OF CANCER THERAPY IN CHILDREN AND ADOLESCENCE

Pamela L. Cummings, R N, B.S.N.

I. Scope of the Problem

A. Prevalence of long-term survivorship

B. Issues related to cost of cure

C. Psychosocial impact of late effects of pediatric cancer survivor and family

II. Factors Contributing to Survival Rates of Childhood Cancer

A. Race

B. Type of Cancer

C. Survivorship Distribution vs Childhood Cancer incidence at diagnosis

III. Late Effects in Multibody System (ROS)

A. Central Nervous System

1. Late Effects:

2. Causes:

3. Treatment:

B. Peripheral Nervous System

1. Late Effects:

2. Causes:

3. Treatment:

C. Vision / Hearing

1. Late Effects:

2. Causes:

3. Treatment:

D. Teeth/Salivary Glands

1. Late Effects:

2. Causes:

3. Treatment:

E. Cardiovascular System

1. Late Effects:

2. Causes:

3. Treatment:

F. Pulmonary System

1. Late Effects:

2. Causes:

3. Treatment:

G. Musculoskeletal System:

1. Late Effects:

2. Causes:

3. Treatment:

H. Gastrointestinal System

1. Late Effects:

2. Causes:

3. Treatment:

I. Genitourinary (Kidney/Urinary Tract)

1. Late Effects:

2. Causes:

3. Treatment:

J. Endocrine/Gonadal Function and Reproduction

1. Ovaries

a. Late Effects:

b. Causes:

c. Treatment:

2. Testes

a. Late Effects:

b. Causes:

c. Treatment:

3. Thyroid

a. Late Effects:

b. Causes:

c. Treatment:

4. Hypothalamic-pituitaryoxis

a. Late Effects:

b. Causes:

c. Treatment:

K. Oncogenesis

1. Second Malignancy

a. Estimates of second malignancy 5-17% 20 years after diagnosis

b. 20 times greater than the general population

c. treatment factors

d. host factors

L. Psychosocial Complications

1. Health and Life Insurance

2. Marriage and Divorce

3. Employment

4. Self-concept/ Self-esteem/ Body Image

5. Social Consequences

6. Lifestyle

UNIVERSITY OF KANSAS MEDICAL CENTER

PEDIATRIC ONCOLOGY OUTREACH TO HUNGARY

NURSING SYLLABUS

BY

Pamela L. Cummings, R.N., B.S.N.

E. Lavonne Ridder, R.N., M.A./M.S.(N)

Susan Siemsen, R.N., M.A.

Tribahawan Vats, M.D.

Support for the Pediatric Oncology Outreach to Hungary project, by a grant from the U.S. Agency for International Development, is gratefully acknowledged.

Translated into Hungarian by:
John J. Kepes, M.D.

English and Hungarian transcription by:
Linda L. Rock, B.S.

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ELÖSZÓ

Egy terv és elképzelés, amely valóra vált: a Kansasi orvosegyetem gyermekonkológiai munkatársai anyagi támogatást kaptak hogy helyszini kollaborációt hozzanak létre az Országos Idegszebészeti Tudományos Intézet és a Semmelweiss Orvostudományi Egyetem II sz. Gyermekklinika onkológus orvosaival és gyermekonkológus nővéreivel, hogy egy klinikai kutató program segitségével csökkentsék a magas halálozást mely Magyarországon a gyermekkori daganatos betegségeket kiséri.

A munka ugy lett meghatározva, hogy a gyermekonkológiai beteg mindent átfogó és holisztikus kezelést kapjon. Az itt következő irányvonalakat a Kansasi Orvostudományi Egyetem és Kórház gyermekonkológus nurse-klinikusai dolgozták ki.

A továbbiakban az olvasó meg fogja találni a részletes tudnivalókat melyek befolyásolhatják a gyermekonkológiai betegek kezelésének nívójat. Reméljük, hogy a tervezet komprehenziv volta lehetővé teszi hogy individuális betegek és intézetek kezelési eredményei ennek előnyét lássák.

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Kansasi Orvosegyetem
Gyermek Hematológia és Onkológia

Ajánlott tanulnivalók, tárgyak

1. Leírja az ápolásban végbement fejlődést.

2. Kibővíti az alaptudást a gyermekonkológiai betegségeket illetően.

3. Taglalja a rákbeteg gyermek legidőszerűbb kezelését.

4. Hasznosítja a gyakorlati tudást a gyermekonkológiai esetek sürgősségének felmérésében és meghatározásában.

5. Hasznos útmutatást ad a rákbeteg és családja számára az onkológiai problémák megoldásához.

6. Megtárgyalja, milyen módon közelitsünk az onkológiai beteghez munkánk során, milyen forrásokat használhatunk.

AZ EREDMÉNYEK KRITÉRIUMAI

1. Az amerikai ápolás (nursing) specializált és haladott szerepét megosztani, előadások, írott anyagok, audio-vizuális segédeszköz és megbeszélések utján. Minden tanuló együtt fog dolgozni egy KUMC Pediatric Oncology Nurse Cinician-nel, megfigyelve és segitve munkájukat. Kiértékelés majd következik hazatérés után az otthoni intezetbe, megfigyelve a változásokat viselkedésben és a munka-klima változásában.

2. Irott anyagok, előadások, audio-vizuális segéd-eszközök, megbeszélések használatával es asszisztálva a gyerekek megsegitésében kulömböző betegségi állapotokaban, kurrens informacio daganatos betegségekről és kezelesükről meg lesz osztva. Kiértékelés formája lesz papir és ceruza gyakorlatokban és a betegek megfigyelésében a kórtermekben és járóbeteg-rendelés kereteiben.

3. Bemutatások, megbeszélések, írott anyagok és audio-vizuális segéd-eszközökkel probléma-megoldási módszerek lesznek bemutatva. Kiértékelés folyamatban lesz mialatt nurse-klinikusoknak asszisztálnak valamint megfigyelés és osztályozás utján.

UNIVERSITY OF KANSAS MEDICAL CENTER

PEDIATRIC ONCOLOGY OUTREACH TO HUNGARY

IDŐBEOSZTÁS ÁPOLÓNŐK RÉSZÉRE

Első hét.	Hétfő	-	Csütörtök - Általános orientáció a klinikai osztályokon
	Péntek	-	Ápolás szerepe/Kerekasztal megbeszélés
Második hét	Hétfő	-	Klinikai osztályok
	Kedd	-	Didaktikus ülés: Ápolás haladott szerepben
	Szerda	-	Klinikai osztályok
	Csütörtök	-	Fizikai kiértékelés
	Péntek	-	Klinikai osztályok
Harmadik hét	Hétfő	-	Klinikai osztályok
	Kedd	-	Didaktikus ülés: Gyermekgyógyászati onkológia, áttekintés
	Szerda	-	Klinikai osztályok
	Csütörtök	-	Didaktikus ülés - A támogató jellegü ápolás problémai I
	Péntek	-	Klinikai osztályok
Negyedik hét	Hétfő	-	Klinikai osztályok
	Kedd	-	Didaktikus ülés - A támogató jellegü ápolás problémai II
	Szerda	-	Klinikai osztályok
	Csütörtök	-	Didaktikus ülés - Sajátságosan gyermekkori problémák

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1. Gyermekgyógyászati fájdalom kiértékelés és kontrol
2. Beavatkozások előkészitése
3. Nyugtatás (szedálás)

Péntek - Klinikai osztályok

Ötödik hét

Hétfő - Klinikai osztályok
Kedd - Didaktikus ülés - Pszihoszociális problémák gyermekkori malignitásokkal kapcsolatban
Szerda - Klinikai osztályok
Csütörtök - Didaktikus ülés - Továbbképzés

Péntek - Klinikai osztályok

Hatodik hét Ápolók átváltása osztályokról járóbeteg rendelésre Kiértékelés

Hetedik - tizenegyedik hét - Hétfő-Péntek Klinikai osztályok, a tanult anyag alkalmazása

Tizenkettedik hét - Kiértékelés

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BENTFEKVŐ BETEG OSZTÁLYOK

HÉTFŐ		KEDD		SZERDA		CSÜTÖRTÖK		PÉNTEK	
8.00 9.30	Osztályos vizit RN-nel	8.00 9.30	---------->	8.00 9.30	---------->	8.00 9.30	---------->	8.00 9.30	---------->
9.30 10.00	Megbeszélések beosztott orvosokkal és residensekkel	9.30 10.00	---------->	9.30 10.00	---------->	9.30 10.00	---------->	9.30 10.00	---------->
11.00	Vizitek-utáni megbeszélés	11.00	---------->	11.00	---------->	11.00	---------->	11.00	---------->
12.00 1.00	Lunch	12.00 1.00	Lunch	12.00 1.00	Lunch	12.00 1.00	Lunch	12.00 1.00	Lunch
		1.30 4.00	Didaktikus ülés			1.30 4.00	Didaktikus ülés		
1.00 4.00	Betegek és szülők informálása, nevelése, Másnapi betegfelvételek tervezése			1.00 4.00	---------->			1.00 4.00	---------->

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JÁRÓBETEG RENDELÉS

HÉTFŐ		KEDD		SZERDA		CSÜTÖRTÖK		PÉNTEK	
8.00 12.00	Gyermek-Onkológiai rendelés	8.00 12.00		8.00 10.00	Bentfekvő beteg vizit	8.30 10.00		8.30 1.00	Gyermek-Onkológiai rendelés
12.00 1.00	Lunch	12.00 1.00	Lunch	12.00 1.00	Lunch	12.00 1.00	Lunch	12.00 1.00	Lunch
1.30 2.30	Rendelés rendbehozása és adatok dokumentálása	1.30 4.00	Didaktikus ülések			1.30 4.00	Didaktikus ülések		
2.30 3.30	Válaszolni betegek és szülők telefon üzeneteire Koordinálás a közösségi forrásokkal és levelezés			2.30 3.30	<——>			2.30 3.30	<——>
3.30 4.30	Befejezni korábbi munkát. Készülés másnapi rendelésre			3.30 4.30	<——>			3.30 4.30	<——>

ÁPOLÁS MINT EGY HALADOTT SZEREP

Pamela L. Cummings, R.N., B.S.N.

I. Történelmi távlat

A. Címek

1. Ápoló klinikus
2. Klinikai ápoló specialista (szakember)

B. Eredet

1. Már az 1900-as évek elején ápolónőket mint specialistákat dezignálták
2. Cél
3. Továbbképző tanulmányok

   a. Klinikai gyakorlat
   b. Képzés
   c. Adminisztráció
   d. Kutatás

4. Tényezők, melyek hozzájárultak az ápolás mint haladott szerep kifejlődéséhez.

   a. funkcionális előkészités

   b. klinikai előkészités

   c. kórházi követelmények megnövekedése

   d. ápolás átalakulása a magán (privát) szolgálattól a felvigyázó modelre a kórház bürokráciai strukturáján belül

C. Az onkologiai ápolás mint specialitás kialakulása.

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HALADOTT PRAXIS STANDARDOK ONKOLOGIAI ÁPOLÁSBAN

I. Professzionális praxis standardok

Standard I.	Közvetlen ápoló-gondozói funkció
Standard II.	Koordinácios funkció
Standard III.	Konzultáns funkció
Standard IV.	Nevelői funkció
Standard V.	Kutatási funkció
Standard VI.	Adminisztrációs funkció

II. Professzionális végrehajtás standardok

Standard VII.	Professzionális (szakmai) fejlődes
Standard VIII.	Etika
Standard IX.	Legális ugyek
Standard X.	Minőség biztositása
Standard XI.	Egészségügyi ellátás politikája

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KURRENS TÉMÁK ÁPOLÁSBAN

LAVONNE RIDDER, R.N., M.A.

I. Karrier fejlődése ápolásban

A. Fázisok.

1. Fantázia
2. Tentativ
3. Realisztikus
4. Várakozás
5. Adjusztálás

B. Feladatok

1. Kikristályosodás
2. Specifikus meghatározás
3. Végrehajtás - implementáció
4. Stabilizálás
5. Konszolidáció és további haladás

II. Stratégiák az ápolás megjelenési formájának változtatására

III. Ápolók, akik kockázatokat vállalnak

IV. Professzionális hatalom

V. Etikai dilemma

VI. Ápolás (nursing) kutatási területei és ápolási tudás fejlesztése.

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BIBLIOGRAPHY

Chaska, N. L. (Ed) (1990) The Nursing Profession Turning Points St. Louis: The C. V. Mosby Company

McCloskey, J. C., Grace, H. K. (Eds) (1985) Current Issues in Nursing (2nd ed) Boston: Blackwell Scientific Publications.

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GYERMEKKORI EGÉSZSÉGÜGYI ANAMNÉZIS IRÁNYVONALAI

Susan Siemsen R.N., M.A.

Információ identifikációra

1. Név
2. Cím
3. Telefon
4. Kor és születési év-hónap-nap
5. Faj
6. Nem
7. Vallás
8. Nemzetiség
9. Az intervju dátuma
10. A felvilágositást szolgáló személy neve

Fő panasz

Jelenlegi betegség

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Személyes / szociális anamnézis-történet

1. Otthoni és közösségi környezet

2. Családtagok foglalkozása és tanultsági foka

3. Kulturális és vallásos tradiciók

4. Házastársi és szexuális történet

A beteg profilja (összefoglalás)

1. Egészségi állapot

2. Pszihológiai állapot

3. Szociális-gazdasági státus

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Általános irányvonalak ápolói kiértékelésre

A. Általános

1. Mérések

a. magasság

b. súly

c. fejkörfogat

d. vitális jelek

e. vérnyomás

2. Általános megjelenés

3. Bőr

4. Nyirokcsomók

B. Szisztémák áttekintése

1. Fej

2. Nyak

3. Szemek

4. Fülek

5. Száj és torok

6. Mellkas

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7. Tüdők

8. Szív

9. Has

10. Nemiszervek

11. Hát és végtagok

C. Neurológiai

1. Viselkedés

2. Kognitiv-perceptuális fejlődés

3. Motor funkciók

4. Érzési funkciók

   a. hallás
   b. latás

5. Cerebelláris funkciók

6. Reflexek

7. Agyidegek

8. Nem pontos ("Soft") jelek-tünetek

D. Fejlődés áttekintése

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E. Anamnézis (mult történet)

1. Születés története
2. Tápláltatás története
3. Korábbi betegségek, sérülések vagy műtétek
4. Allergiák
5. Védőoltások
6. Kurrens gyógyszerelés
7. Növekedés és fejlődés
8. Szokások

F. Szisztemák áttekintése

1. Általános
2. Bőr
3. Fej
4. Szemek
5. Fülek
6. Orr
7. Száj, fogak, nyelv és íny

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8. Torok és nyak

9. Mellkas

10. Légző szervek

11. Szív és keringés

12. Gyomor-béltraktus

13. Nemi szervek, vizeletkiválasztás

14. Nőgyógyászat-szülészet

15. Izom és csontrendszer

16. Neuropszihiátriai állapot

17. Nyirokrendszer, vérképzőrendszer

18. Belső elválasztású (endokrin) rendszer

G. Család történet

1. Család pedigréje (családfa)

2. Családi-öröklődő betegségek és fejlődési rendellenességek

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ÁLTALÁNOS IRÁNYVONALAK GYERMEKKORI FIZIKAI VIZSGÁLATHOZ

A vizsgálat megfelelő és nem ijesztő-fenyegető helyen legyen végrehajtva.

- A szoba jól legyen megvilágitva semleges színekkel és fényekkel.
- Távolitsunk el minden idegenszerű és potenciálisan ijesztő felszerelést a gyermek látosugarából.
- Legyenek játékok, babák, kitömött állatok és társasjátékok a gyermek számára.
- Ha lehetséges, legyenek szobák külömböző módon dekorálva és felszerelve külömböző-koru gyermekek számára.
- Biztositsunk privátságot, különösen iskoláskoru gyermekeknek és serdülőknek.
- Ellenőrizzuk, hogy a felszerelések és eszközök jól működnek és elérhetőek a vizsgálat félbeszakitása nélkűl.

Biztositsunk időt játékra és megismerkedésre.

- Beszélni az ápolóval
- Szemkontaktust teremteni
- Elfogadni a felajánlott műszert-szerszámot
- Megengedni fizikai érintést

A megvizsgálandó gyermek választhat, hogy a vizsgáló asztalon vagy a szülő ölében üljön.

Ha nincsenek jelei a készségességnek, a következő technikákat lehet használni.

- Beszélgessünk a szülőkkel mialatt lényegileg "nem veszünk tudomást" a gyermekről: fokozatosan irányitsuk a focust a gyermekre vagy valamilyen kedvenc tárgyára, mint például egy baba.

- Tegyünk dicsérő megjegyzéseket a gyermekről, a megjelenését, öltözetét vagy kedvenc tárgyát illetően.

- Mondjunk el egy vicces történetet vagy egy egyszerü trükkot mutassunk neki.

- Legyen kéznél egy nem-fenyegető "barát" mint pl. egy kézibáb, "beszéljen" a gyermekkel az ápoló/apolónő nevében.

Ha a gyermek nem hajlandó kooperációra, a következő technikákat alkalmazzuk:

- Probáljuk meghatározni a nem kooperáló viselkedés okát: vegyük figyelembe a lehetőséget hogy ha egy gyermek tulságosan fél egy férfi vizsgálótól, talán volt egy korábbi traumatikus tapasztalata, beleértve szexuális bántalmazást.

- Probáljuk a gyermeket és a szülőt belevonni a processzusba, vagy ha az látszik helyénvalónak, kérjük meg a szülőt hogy hagyjon magunkra a gyermekkel.

- Kerüljük el a túl hosszadalmas magyarázgatást a vizsgálati processzusról.

- Szilárd és közvetlen irányitást adjunk az elvárt viselkedésről Végezzuk el a vizsgálatot amilyen gyorsan csak lehet.

- Egy segitő gyengéden fogja le a gyermeket

- Minimálisra fogjunk mindenféle félbeszakitást vagy stimulációt

  Korlátozzuk a személyek számát a szobában.

  Használjunk egy elszigetelt szobát.

  Nyugodt és magabiztos hangot alkalmazzunk.

- Kezdjük a vizsgálatot egy nem-fenyegető módon, fiatal vagy félős gyermekek esetében.

- Használjunk olyan aktivitásokat melyeket mint játékokat lehet bemutatni, mint peldául az agyidegek vizsgálatát vagy a Denver Developmental Screening Test (DDST) egyes részeit.

- Használjunk olyan módszereket mint "Simon mondja" hogy felbátoritsuk a gyermeket hogy vágjon egy grimaszt, szoritsa meg a kezünket, álljon egy lábon, stb. stb.

- Használjuk a "papir-baba" technikát:

Fektessük a gyermeket hanyatt a vizsgáló asztalra vagy a padlóra, egy nagy iv papirra.

Rajzoljuk körül a gyermek test-körvonalait

Használjuk a test körvonalait hogy megmutassuk mi lesz megvizsgálva, peldául rajzoljunk egy szivet és "hallgassuk meg" a sztetoszkóppal mielőtt ugyanazt az aktivitást végeznénk a gyermeken.

Ha egy család több gyermeke lesz megvizsgálva, kezdjük a legjobban kooperáló gyermekkel.

Vonjuk bele a gyermeket a vizsgálat processzusába:

- Engedjünk választást hogy az asztalon vagy a szülő ölében akar-e ülni?

- Engedjük meg hogy tartson vagy csináljon valamit eszközökkel

- Bátoritsuk fel a gyermeket hogy vizsgáló eszközöket használjon babán, családtagon vagy a vizsgálón.

- Az eljárás minden lépését magyarázzuk el egyszenü nyelven

Vizsgáljuk a gyermeket egy kényelmes és biztonságot nyujtó pozicióban.

- Ülve a szülő ölében.

- Egyenesen felülve ha légzési nehézségei vannak.

Vizsgáljuk a testet egy szervezett sorrendben (legtöbbször fejtől lábujjakig) a következő kivételekkel:

- Változtassuk a vizsgálat sorrendjét hogy külömböző koru gyermekek szükségleteinek megfeleljen

- Utolsónak hagyjuk a fájdalmas területeket

- Surgősségi helyzetben vizsgáljuk meg a vitális funkciókat (légutak, légzés és keringés) és sérült területeket elsőknek.

Nyugtassuk meg a gyermeket vizsgálat közben, elsősorban testét illető esetleges aggodalmakat a pubertás során

Beszéljük meg a vizsgálat eredményeit a családdal a vizsgálat befejeztével.

Dicsérjük meg a gyermeket a vizsgálat közbeni jó együttműködésért:

adjunk valami jutalmat például egy kis játékot vagy egy nyalókát.

Testrészek-szisztémák áttekintése

ÁLTALÁNOS - egészségi állapot összefoglalóan, fáradtság, uj és/vagy nem-megmagyarázott súlygyarapulat vagy vesztés, mennyi idő alatt történt egyik vagy másik, milyen tényezők járulhattak ehhez hozzá (változás az étkezésben,betegség, étvágy-változas) testgyakorlási teherbirás, lázak (milyen napszakban), gyakori fertőzések, általános képesség a mindennapi élet aktivitásai véghezvitelében.

BŐR - viszketegség, pigment vagy más szinváltozások, pattanások, sömörök, kiütések (lokalizáció) könnyű zúzódási tendencia, apró vérzések, túlzott szárazság, általános turgor, köröm rendellenességek vagy elváltozások, hajnövekedés vagy haj-vesztés, változás a hajszinben (serdülő korban esetleg hajfestékek vagy más potenciálisan toxikus anyagok használata, peldául göndör haj kiegyenesitésére).

FEJ - Fejfájások, szédülés, sérülés (speciális részletekkel)

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SZEMEK - Látási problémák (kérdezzünk viselkedés felől mely homályos látást indikálhat, mint például tárgyakba beleütközés, ügyetlenkedés, túl közel ülés a televizióhoz, könyvet túl közel az archoz tartva olvasni, irni a fejet tulságosan az iróasztalra hajolva tartva, gyakori pislogás, szemek dörzsölése, a fejet szokatlan szögben megdöntve tartani, bandzsitás, szemfertőzések, szemhéj ödéma, túlzott könnyezés, szemüveg vagy kontakt lencsék használata), az utolsó szemészeti vizsgálat időpontja.

ORR - Orrvérzések (epistaxis, állandó vagy gyakori váladékozás az orrból, vagy eldugulás az orrjáratokban (légzési nehézségek), szaglóérzék romlása

FÜLEK - Fülfájások, váladékozás, hallás-veszteség tünetei (kérdezzünk erre utaló viselkedésre, mint például kérések-kérdések megismételtetése, hangos beszéd, figyelmetlen viselkedés) esetleges előző hallás-vizsgálat eredményei.

SZÁJ - szájon keresztüli légzés, iny-vérzés, fogfájás, problémák fogkeféléssel, csecsemőben fogzási nehezségek (tünetek), mikor volt az utolsó látogatás fogorvosnál, különösen ha tejfogak már mind jelen vannak)

TOROK - torokfájások, nyelési nehézségek, fulladozás (különösen rágás közben - talán helytelen rágási szokásokból eredően) rekedtség vagy más hang-rendellenességek

NYAK - fájdalom, mozgáskorlátozás, merevség, nehezen tudja a fejet egyenesen tartani (torticollis), pajzsmirigy megnagyobbodás, megnagyobbodott nyirokcsomók vagy más szövetszaporulat

MELLKAS - mell megnagyobbodás, váladékozás, csomók, megnagyobbodott hónalji nyirokcsomók (serdülő lányokat kérdezzük meg a mellek önvizsgálatáról)

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LÉGZŐSZERVEK - krónikus köhögés, gyakori megfázások (hányszor évenként), hörgő-jellegű légzés, légszomj nyugalomban vagy munka közben, légzési nehézségek köpet produkálása, fertőzések (pneumonia, tuberculosis) utolsó mellkas röntgen dátuma.

SZÍV ES KERINGÉS - cyanosis, kifáradás testmozgás közben, anamnézisben szívzörej vagy rheumás láz, anémia, utolsó vérsejtszámlálás, vércsoport, vérátömlesztés a közelmultban.

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GYOMOR-BÉLTRAKTUS - (ennek nagy része, ami étvágyra, étel tűrésére, és kiválasztásra vonatkozik másutt már lett kérdezve) itt összpontositsunk hányinger, hányásra (ha ez nem kapcsolatos evéssel akkor agydaganat, vagy koponyaűri nyomásnövekedés jele lehet) sárgaság bőrben vagy a sclérában, büfögés, szelek eresztése, bélműködés megváltozása (vér a székletben, szinváltozás, hasmenés vagy székrekedés)

HUGY-IVARSZERVEK - fájdalom vizeléskor, gyakori vizelés, nehéz elinditás, sürgősség érzése, vérvizelés, éjjeli vizelési szükséglet, túl nagy mennyiségű vizelés, kellemetlen szag a vizeletben, a vizelet-sugár ereje, urethrából váladék, herezacskónak nagyságváltozása (serdülőben nemi betegség, milyen fajta kezelést kapott) utolsó vizeletvizsgálat dátuma.

NŐGYÓGYÁSZATI - első menstruáció (menarche) ideje, utolsó menstruáció dátuma, szabályosság vagy problémák a menstruálással, hüvelyi váladék-képzés, viszketés, utolsó PAP kenet vizsgálat dátuma és eredményei (belevenni szülészeti anamnézist, ahogy a születési történet alatt lett kifejtve, hogyha vonatkozhat) ha szexuálisan aktiv, milyen foganmzásgátlást használ.

IZOM és CSONTRENDSZER - gyengeség, ügyetlenség, koordináció hiánya, szokatlan mozdulatok, hát vagy izületi merevség, izom fájdalom vagy görcsök, rendellenes járás, deformitások, törések, súlyosabb szalag huzódások, aktivitás szintje.

IDEGGYÓGYÁSZATI - epilepsziás rohamok, remegés, szédülés, emlékezetvesztés, általános érzelmi állapot, félelmek, lidérc-álmok, beszéd problémák és különös szokások.

BELSŐ ELVÁLASZTÁSI SZERVEK - időjárás változások rossz tűrése, túlerős szomj-érzet, túlerős izzadás, sós íz a bőrön, túlkorai jelei a pubertásnak.

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NEUROLÓGIAI KIÉRTÉKELÉS

Elmei státus

VIZSGÁLATI MÓD:

Meg kell figyelni viselkedést, hangulatot, érzelmi állapotot, környezet iránti általános orientációt, eszméleti állapotot

KIÉRTÉKELÉS:

Motor funkciók

VIZSGÁLATI MÓD:

Meg kell vizsgálni izom erőt, tónust és fejlettséget

Meg kell vizsgálni kisagyi működést:

- Ujjat-az-orrhoz - A gyermek karja legyen kinyujtva és érintse meg az orrát a mutató ujjával.

- Sarok-sipcsont teszt: - A gyermek álljon és egyik lába sarkát húzza végig a másik láb sipcsontja mentén.

- Romberg teszt - A gyermek álljon egyenesen, lábait összetéve és szemeit behunyva.
- A gyermek érintse mindegyik ujjahegyével a hüvelykujját, gyors egymásutánban
- A gyermek paskolja meg a combját a kezével: először tenyérrel aztán kézháttal, gyors sorozatban
- A gyermek ütögesse a vizsgáló kezét a lábfejével amilyen gyorsan csak tudja.

KIÉRTÉKELÉS:

Érző rendszer

ELJÁRÁS:

Vizsgáljuk látást és hallást

Érzőrendszer hibátlansága:

- Érintsd a bőrt könnyedén gombostűheggyel és kérdd a gyermeket hogy mutasson az érintett helyre csukott szemmel

Érzési diszkrimináció:

- Érintsd bőrt gombostűheggyel és vattával: a gyermek írja le az érzést mint éleset vagy tompát.
- Érintsd bőrt hideg és meleg tárggyal (mint pl. a reflexkalapács fém és gumi végével): a gyermek külömböztesse meg a hőmérsékletet
- Két gombostűt használva, érintsd meg a bőrt egyszerre két vagy egy tűvel: a gyermek külömböztesse meg, hogy egy vagy két tű lett használva

KIÉRTÉKELÉS:

Reflexek (mély ín-reflexek)

ELJÁRÁS:

Biceps

- Tartsuk a gyermek karját részben hajlitott könyökkel a kezünkben, hüvelykujjunkkal a könyökhajlat felett; üssük meg a hüvelykujjunk körmét a reflex kalapáccsal

Triceps

- Hajlitsuk a kart könyökben és nyugtassuk a gyermek tenyerét a kezünkben: üssük meg a triceps inát

- Másik módszer - ha a gyermek hanyatt fekszik, nyugtassuk karját a mellkasán és üssük meg a triceps ínat

Brachioradiális

- Nyugtassuk az alkart ölben vagy hason, nyujtott karral és tenyérrel lefelé üssük meg a radiust kb. 2.5 cm-el (gyermek nagyságától függően) a csukló felett

Térd vagy patelláris reflex

- Ültessük a gyermeket a vizsgálóasztal szélére, vagy a szülő ölébe, a lábak térdben meghajitva és szabadon lóbálva; üssük meg a patella inát közvetlenül a térdkalács alatt

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Achilles

- Használd ugyanazt a pozíciót mint a térd reflexhez; támaszd fel a lábat könnyedén a kezeddel és üsd meg az Achille ínt

Boka (Achilles) klonus-

Kernig tünet

- Hajlitsd meg a hanyattfekvő gyermek lábát csipőben; figyelj fájdalomra vagy ellenállásra

Brudzinski tünet

- A hanyattfekvő gyermek fejét hajtod előre: figyeld meg jelez-e fájdalmat és behajtja-e a csipőjét és térdeit

Agyidegek

- Lásd agyidegek kiértékelését

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NEUROLOGIAI KIÉRTÉKELÉS

MEGJEGYZÉSEK:

- Szubjektiv benyomások a vizsgálat alatti megfigyelésekre alapozódnak

- Objektiv leleteket lehet elérni fejlődési tesztekkel mint pl. DDST

SZOKÁSOS LELETEK:

- Minden feladatot sikeresen végrehajt nyitott és csukott szemekkel egyaránt

MEGJEGYZÉSEK:

- Nehéz lehet óvodáskornál fiatalabb gyerekeket tesztelni

- Figyeljünk meg minden sutaságot vagy koordináció hiányát teljesitményekben

SZOKÁSOS LELETEK:

- Romberg teszt - Nem dől oldalra vagy esik

MEGJEGYZÉSEK:

- Ha a gyermek elesik, vagy egyik oldalra dűl, az abnormális és úgy hivják hogy ROMBERG tünet

SZOKÁSOS LELETEK:

- Tudja a tűszúrást lokalizálni

MEGJEGYZÉSEK:

- Csak steril tűt vagy más hegyes tárgyat (fogpiszkálót) szabad használni és nagyon kell vigyázni, hogy a bőrt ne szúrjuk át

- Hasonlitsuk össze az érzéseket szimmetrikus területeken distális és proximális pontokon

SZOKÁSOS (Normális) LELETEK:

- Képes megkülömböztetni érzés tipusokat és hőmérsékletet
- Minimális távolság két-pont diszkriminációra az ujjon 2-3 mm

MEGJEGYZÉSEK:

- Figyeljük meg van-e nehézség a teszt végrehajtásban, különösen idősebb gyermeknél

SZOKÁSOS LELETEK:

- Biceps: az alkar részleges behajtása

MEGJEGYZÉSEK:

- Használjunk megerősitő technikákat a reflex aktivitás megerősitésére:

  Felső végtag reflexeihez: szólitsuk fel a gyermeket hogy szoritsa össze fogait, vagy szoritsa össze erősen a kezét a nem-vizsgált oldalon

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SZOKÁSOS LELET: (normális)

- Triceps - részleges kiegyenesitése az alkarnak

MEGJEGYZÉSEK:

- Alsó végteg reflexvizsgálatához - a gyermek kulcsolja össze az ujjat és húzza egyik kezét el a másiktól vagy szoritsa össze a kezeit

Szokásos osztályozása a reflexeknek

0 fok				0 Hiányzik
1 fok				+ Csökkent
2 fok			+	+ Normális
3 fok		+	+	+ Élénkebb mint normális
4 fok	+	+	+	+ Hyperaktiv (klonus)

Figyeljük meg ha a reflexek asszimetrikusak, csökkentek vagy hyperaktivak

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SZOKÁSOS (Normális) LELETEK:

- Brachioradialis - Alkar behajtása és supináció (fordítás úgy hogy tenyér felfelé nézzen)
- Patelláris - részleges kinyujtása a lábszárnak
- Achilles - a láb plantaris hajtása: (lábfej lefelé néz)
- Boka klonus - nem következik be rángás

SZOKÁSOS (Normális) LELETEK:

- Kernig - manőver nem vált ki sem fájdalmat sem ellenállást

MEGJEGYZÉSEK:

- Ezeket a speciális reflexeket teszteljük ha meningeális (agyhártya) irritációt (ingerlékenységet) gyanitunk.

SZOKÁSOS (NORMÁLIS) LELET:

- Brudzinski - nem okoz fájdalmat vagy kapcsolatos mozgást

MEGJEGYZÉSEK:

- Pozitiv tünet azonnali kórházi felvételt tesz szükségessé

- Agyidegek tesztelése része lehet a neurológiai vizsgálatnak, vagy integrálni lehet más rendszerek vizsagálatába, például a szemészeti vizsgálathoz tartozik a II., III., IV. és VI. agyideg működése.

- Agyidegeket általában lehet tesztelni ovodáskoru és idősebb gyermekekben.

- Fel kell jegyezni, ha a megkivánt feladatok végrehajtását nem tudja a beteg keresztül vinni

Abnormális akaratlan izom működés mozdulatok

Név (terminológia)	Leirás
Ataxia	Súlyos inkoordináció, nely rosszabodhat csukott szemmel
Görcs	Szokatlan feszesség az izomzatban
Görcsösség	Elhuzódó és állandósult kontrakció az izomban, melyet clonus jellemez (váltakozó elernyedés és összehúzódás az izomban) és túlzott reflexek
Merevség	Képtelen behajtani egy izületet
Remegés (tremor)	Állandosult kis-kilengésű mozgások

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Abnormális akaratlan izom működés mozdulatok (folytatás)

Név (terminológia)	Leírás
Rángás	rövidlejáratu görcsös mozdulatok
Chorea-szerü mozdulatok	Gyors, összeránduló, nem koordinált (összehangolt) mozdulatok melyek eltünnek az izomzat elernyedésekor
Dystonia végtagokban	Lassu rándulásu mozdulatok vagy a törzsben
Asszociált (társult) mozdulatok	Egyik izom akaratlagos (szándékolt) mozgását kiséri egy másik izom akaratlan mozgása
Tükör mozdulatok	Ugyanaz mint asszociált (társult) mozdulatok, kivéve hogy ez szimmetrikus izomcsoportokkal történik

GYERMEKGYÓGYÁSZATI

KIÉRTÉKELÉS

I. Kiértékelés, a betegség történetét (anamnézist) felvenni a gyermektől és családjától.

GYERMEKKORI EGÉSZSÉGTÖRTÉNET VÁZLATA

Személyazonossági információ

1. név
2. cím
3. telefonszám
4. kor es születési dátum
5. faj
6. nem
7. vallás
8. nemzetiség
9. az intervju dátuma
10. informáló (a személy aki a személyazonossági adatokat adta)

Legfőbb panasz

Ez képviseli a speciális okot mely a gyermeket a kórházba, vagy járóbetegrendelésre hozta.

1. korlátozott rövid megállapitás
2. egy vagy két tünetre legyen korlátozva
3. egy konkrét panaszra vonatkozzon
4. a gyermek vagy a szülő saját szavaival kell leirni
5. el kell kerülni diagnosztikus terminusokat vagy forditást
6. meg kell határozni a tünetek időtartamat (mióta?)

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JELEN BETEGSEG

A legföbb panasz leirása legkorábbi megnyilvánulásától kifejlődésen át a jelenkorig

Négy fontos összetevő

1. a kezdeti szakasz részletei
2. teljes története az átmeneti szakasznak
3. jelen státus
4. az ok amiért most jött segitségért

Hogyan kell analizálni egy tünetet

1. kezdet

   a. mikor kezdődött?
   b. milyen módon kezdődött? (fokozatosan vagy hirtelen?)
   c. kiváltó és elősegitő tényezők melyek a kezdettel

      kapcsolatosak

      (érzelmi zavarok, fizikai kimerülés, fáradtság,

      testműködés, terhesség, környezet, sérülés, fertőzés,

      toxinok, allergének, gyógyszerek, stb.)

2. jellegzeteségek

   a. jelleg
   b. helye és kisugárzása (fájdalomnak)
   c. intenzitás és súlyosság
   d. idő-jelleg (állandó vagy megszakitott, milyen sokáig tart mindegyik epizodus?)
   e. súlyosbitó és enyhitő tényezők
   f. társult szimptomák

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3. Lefolyás a kezdet óta

a. előfordulás

1. egyetlen akut attak
2. visszatérő akut attakok
3. mindennapi előfordulás
4. periodikus előfordulás
5. folyamatos chronikus epizodsok

b. haladás (javulás, rosszabodás, változatlan)

c. gyógyszerelés hatása

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MULT TÖRTÉNET

Tartalmaz adatokat a gyermek égeszségi állapotának minden korábbi tényezőjére vonatkozóan, és koncentrálódik több olyan területre, amelyet általában kihagyunk ha felnőttől veszünk fel kórtörténetet, pl. születés lefolyása, csecsemokőri táplálás, védőoltások, növekedés és fejlődés.

1. Születés
   a. az anya egészségi állapota terhesség alatt
   b. vajudás es szülés
   c. a csecsemő állapota közvetlenül születés után

2. Táplálás

   (változó a gyermek korától függően)

   a. csecsemő táplálás - táplálás tipusa (szoptatás, formula) változások a táplálási szokásokban, mennyi idó kell egy etetéshez, étvágy, fogyasztott mennyiség, vitaminok hozzáadása, súlyváltozás, etetésel kapcsolatos problémák, hasmenés, bélgörcs, nem hajlandó enni, "felköpés", milyen módszereket használtak ilyen problémák ellen?

b. <u>idősebb gyerekek</u> - "diéta napló", megkérni a szülőt, hogy leirja "mit evett a gyermek tegnap" es hogy ez egy egy "tipikus nap" volt-e? Át kell nézni a feljebb leirt csecsemő-kori táplálást illető módszerekkel ahol ez alkalmazható, és a táplálási történetnek megfelelően, ha indikált, megfelelő tanácsokat kell adni, ha szükséges, egy részletesebb táplálkozási kiértékelésre egy Regisztrált Dietetikushoz kell küldeni

3. Korábbi betegségek, sérülések, műtétek

<u>Betegségek</u>

a. fertőző betegségek kezdet, tünetek, lefolyás, tartam

b. ragályos betegségek (gyermekbetegségek) bárányhimlő, rubeola, mumpsz, herpes zoster, cytomegalovírus fertőzés, hepatitis. Sorold fel kezdetet, tüneteket, lefolyást és tartamot.

<u>Sérülések:</u> dátum, milyen specifikus sérülés, kezelés

<u>Műtétek:</u> dátum, műtét jellege, komplikációk, ki volt a sebész, melyik kórház?

Korházi felvételek Felvétel dátuma, helye, diagnózis, kezelés, elbocsátás dátuma, orvos neve

4. Kurrens (jelenlegi) gyógyszerelés

   a. gyógyszerallergiák

   b. kurrens gyógyszerelés: minden gyógyszernél le kell írni nevet, adagolást, milyen gyakran kapja, tartam és a gyógyszerelésre vezető ok.

5. Védőoltások:

   a. Minden védőoltásnak, beleértve a csecsemőkori oltásoknak legyen meg a dokumentációja.

   b. Minden felsorolva: a betegség neve, adagolás, milyen korban lett beoltva, és volt-e valamilyen káros reakció az oltás után?

   c. Meg kell kérdezni kapott-e valaha lószérumot vagy egyéb idegen szérumot, kapott-e nemrégen gamma globulint, vérátömlesztést, vagy allergiás-e tojás-albuminra?

   d. Meg kell kérdezni kapott-e tuberkulozis (tuberculin) bőr-tesztet. Ha a válasz igen, be kell írni pozitív vagy negatív volt az intrakután teszt eredménye?

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6. Növekedés és fejlődés:

Fontos adatok a korábbi növekedési jellegre:

a. körülbelül mi volt a súlya 6 hónapos, 1 éves, 2 éves és 5 éves korban?

b. Hossz (magasság) 1 és 4 éves korban?

c. fogzás, beleértve fogzás korát és a fogak számát.

Fejlődési határpontok:

a. milyen korban tartotta fent fejét

b. milyen korban ült egyedül támogatás nélkül

c. milyen korban járt egyedül támogatás nélkül

d. milyen korban mondta az első értelmes szót

e. hányadik osztályba jár

f. milyen jegyeket kap

g. interakció más gyerekekkel és felnőttekkel

Felhasználható kiértékelésre a denveri Fejlődesi Szűrőteszt (Denver Developmental Screening Test, DDST)

7. Szokások

a. körömrágás, hüvelykszopás, szokatlan tárgyak-anyagok evése (pica), rituálék, pl. "biztonsági" pelenka vagy játék, szokatlan mozdulatok

b. mindennapos élet aktivitásai: hánykor megy aludni és hánykor kel hány órát szundit-e, milyen testgyakorlást űz, székelés és vizelés rendszeressége, milyen korban lett toalett-re szoktatva, előfordul-e napkőzbeni vagy éjjeli bevizelés?

c. általában milyen kedve van és hogy reagál csalódásokra

d. használ-e alkoholt, drógokat, kávét vagy cigarettát

e. fog hygiene

f. a család biztonsáig szokásai

8. Szisztémák áttekintése:

a. speciális áttekintése mindegyik testi szisztémának, hasonlóan a fizikai vizsgálat sorrendjéhez:

9. Családi anamnézis

a. elsősorban abból a célból hogy esetleges öröklődő vagy családi betegséget találjunk szülőkben vagy gyermekekben.

b. magában foglalja házassági kacsolatokat is, milyen támogatást lehet remélni közeli és távoli rokonoktól, korkülömbségek testvérek között.

c. magában foglalja anyai és apai felmenőket, testvéreket, gyermekeket, mindegyikre az információ tartalmazzon kort, egészségi állapotot, ha él, halálok ha már nem él, és bármilyen indikáció a következőkre nézve:

szivbetegség
magas vérnyomás
daganatos betegség
diabetes mellitus
kóros kővérség
veleszületett fejlődési rendellenességek
szellemi visszamaradottság
allergiák
asthma
tuberkulozis
sarló-sejt betegség (sickle cell anemia)
rángógörcsök
elmebetegség, emocionális problemák
syphilis
rheumás láz

10. Személyes és szociális anemnézis

Magában foglalja az Összes személyes, szociális és gazdasági tényezőket melyek befolyásolják a gyermek és családja általános pszihológiai egészségét.

Összpontositsunk:

a. otthoni és közösségi környezetre
b. családtagok foglalkozása és tanultsági foka
c. kulturális és vallási tradiciók
d. földrajzi fekvés
e. szülő és gyermek házassági és szexuális története
f. anyagi állapot, biztositás
g. iskolai történet és tanulmányi haladás

11. A beteg "profil" - ja

Összefoglalása gyermek egészségi állapotára vonatkozó benyomásunknak, és a pszihologiai-szociális váltakozó tenyezőkre, melyek befolyásolják a gyermek egészségét mint egészet.

a. egészségi állapot, mint gyakori egészségi problémák melyeket az intervju során felfedeztünk

b. pszihológiai státus, mint családi problémák, pl. válás, kulönélés

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12. Ha a beteg visszatér, áttekinteni

a. szubjektive: főpanasz, jelen betegség története, lényeges mult történet, és a rendszerek áttekintése

b. objektiv: vitális tünetek, fizikai vizsgálat, laboratoriumi leletek, röntgen

c. kiértékelés: diagnózis és problémák listája

d. terv: hogyan közelitjük meg a probléma listát és követjük beteget

II. A gyermek fizikai kiértékelése

A. Általános információ:

(Tabla 1 - Korra speciális irányvonalak gyermekkori fizikális vizsgálatra)

(angol szöveg)

A gyermek megközelitése.

A gyermek kora gyakran befolyásolja milyen sorrendben végezzuk a kiértékelést. Mikor testszisztémakat értékelünk, a fejlódési és chronológiai kort vegyük figyelembe.

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Célok:

1. Minimalizálni a sztresszt és aggódást ami külömböző testrészekkel kapcsolatos
2. kifejleszteni egy bizalommal teljes kapcsolatot a vizsgáló-gyermek-szülő között
3. Maximum előkészitést engedni a gyermeknek
4. Maximalizálni a vizsgálati leletek pontosságát és megbizhatóságát

B. Kiértékelési technikák

A tradicionális négy kategória magába foglalja inspeckciót, tapintást, kopogtatást és hallgatózást

Ezek mindegyike tartalmaz eszközöket melyek lehetővé teszik a vizsgálat végrehajtását, hasznosságát, és pontosságát

Inspeckció: látás, szaglóérzék, hallás, néha izlelés

Tapintás, kopogtatás: kezek és ujjak

Hallgatózás: fülek

Mérések, ugymint magasság (hossz) súly, fejkörfogat, vitális tünetek, vérnyomás, szintén lényeges részei minden fizikai kiértékelésnek.

1. Inspekció

   a. használjuk érzékszerveinket, elsősorban látást, kiertékelésre, összehasonlitásra és elhatározásokra

   b. szükségessé teszi az ügyességet, gyakori ismétlést, hogy megbizhatóan tudjunk külömbséget tenni, normális, határeset és abnormális között.

   c. az inspekció módszerei

      1. érzőszerveink tudatos, szisztematikus és aktiv használata

      2. vizsgáljunk meg minden testrészt, a látható területet szemléljük meg szinre, konzisztenciára tisztaságra, csomókra, szőrzetre, tónusra, mozgásra, viselkedésre, feszültségre, lanyhaságra, szimmetriára, lokalizációra, pozicióra, hőmérsékletre, stb. tekintettel

      3. megfigyelés közben hasonlitsuk össze normal anatómiával és fiziológiával

      4. tudatosan elemezzük viselkedést, úgymint megjelenést, mozgásokat, kapsociatokat, aktivitást szóbelki interakciót, hangulatot, orientációt és irjuk le amit megfigyeltünk

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2. Tapintás

a. tapintás felhasználja az érintést és a tapintóérzést hogy felfedezzen felületes és mély jellegzetességet a testben

b. inspekcióval kombinálva lehet használni, pl. a bőr texturájának a meghatározására

c. használható megvizsgálni a test minden hozzáférhető részét, ugymint szerveket, mirigyeket,ereket, csontokat, izmokat, hajat, bőrt és nyálkahártyákat.

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(1) Tapintás módszerei

(a) nyakat nyirokcsomókra, vagy csecsemő koponyát kutacsokra: ujjheggyel hőmérsékletre: ujjheggyel es kézháttal

(b) vibrálás: mint pl. szivrezgés: tenyérrel

(c) konzisztencia, helyzet-pozició, nagyság: átfogó akció

(d) hasűregi mélyebben fekvő szervek: máj, lép, vesék: kétkezes manőver.

Megjegyzés: Ahhoz hogy bármilyen tapintás hatásos legyen, kűlönösen a belsö szervek mély tapintásához, a gyermeknek teljesen relaxálódni kell. Helyezzük a gyermeket kényelmesen, pl. félig hátradőlt helyzetben a szülő ölében, melegitsük meg kezünket mielőtt megérintjuk, és tereljük el a gyermek figyelmét.

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3. Kopogtatás

a. ha megütjük vagy kopogtatjuk a testfelületet, ez hangot produkál amely összefügg (arányos) az alatta fekvő szővet konzisztenciájaval.

b. Tábla 2 adja a kopogtatási hangok definicióját

c. kopogtatás módszerei

(1) közvetlen - közvetlenul megütni, vagy kopogtatni a test felszint az ujjunkkal, ez használható, ha jól körülirt területeket, pl. csontokat vagy szervek külső határait kopogtatjuk

(2) közvetett - a testfelszinre helyezett ujjunkat kopogtatjuk.

4. Hallgatózás

a. Testből jövő hangok kiértékelése

b. Tábla 2 adja meg a hallgatozás jellegzetes hangjait is.

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c. hallgatózás módszerei

(1) közvetlen: a fülünket közvetlenül a testfelszinre helyezzük

(2) közetett: sztetoszkópot használunk hogy a test belsejéből jövő hangokat átvezesse a nővér füléhez. Két sztetoszkóp tipus van:

(a) nyitott harang: alacsony hangokra, pl. diasztolikus zörejekre, szorosan kell odatapasztani

(b) zárt diafragma:érzékenyebb a magasabb hangokra, nem szükséges szorosan odatapasztani

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C. Gyermekgyógyászati fizikai vizsgálat

Kiértékelés általános irányvonalai

1. Általános.

a. mértékek - Tábla 3. Gyermekkori test növekedés általános irányvonalai

1. magasság
2. súly
3. fejkörfogat
4. vitális jelek
5. vérnyomás

b. általános megjelenés - a gyermek általános megjelenése szubjektive összetevője gyermek fizikai megjelenése, tápláltsági foka, viselkedése, interakció szülőkkel, nővérrel, testvérekkel, testtartás, fejlődés és beszéd

(1) fizikai megjelenés: arc, testtartás, hygiene

(2) tápláltság: jóltáplált vagy alultáplált izomzat, bőralatti zsirszövet

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(3) viselkedés: belértjük a gyermek személyiségét, aktivitás szintjét, reakciója sztresszre, kivánságokra, csalódásra, másokkal való interakció, éberség foka, stimulálásra válasz

(4) fejlődés: a gyermek beszéd-fejlődésének kiértékelése motor képesség, koordináció, és ujabbkori teljesitmény dokumentáljuk DDST-vel (Denver Development Screening Test) ha szükséges

c. bőr - kiértékelni színre, állomány, hőmérséklet, tónus. A hajat is megszemléjük szinre, állományra, eloszlásra és rugalmasságra tekintettel

(1) bőr szín - variációi

(a) sápadtság és szederjesség

(b) pír

(c) apró vérzések

(d) sárgaság

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(2) állomány

(a) nedvesség és hőmérséklet

(b) jelek a bőrön és hegek

(c) gyakori gyermekkori problémák

(i) "bölcső sapka" (hámlik a fejbőr)

(ii) ekcéma (hámlás és lehámlás a fejbőrok, orcákon, térdeken, könyökökön)

(iii) pelenka kiütés

(iv) túlzott szárazság

(3) hőmérséklet

(4) turgor

(a) szövet turgor a bőr rugalmasságát jelenti

(b) fogjuk meg a hüvelyk és mutatóujj között és gyorsan engedjük el.

(c) normális szövet = visszatér normál poziciójába, gyenge bőr turgor: "sátor" - formában marad egy ideig

(d) ödéma - dagadás vagy puffadtság

(5) bőr segédszervei

(a) haj

(b) körmök

d. Nyirokcsomók

(1) kiértékelni mikor megvizsgáluk azt a testrészt melyben találhatók

(2) a szokásos területek ahol nyirokcsomókat tapintunk Tabla 4 ábrában

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(3) főhivatásuk: összegyüjtik a nyirok folyadékot és kiszűrik a baktériumokat és egyéb idegen anyagot mielőtt visszatér a nyirok a keringésbe

2. Fej

a. alak és szimmetria

b. a fej kontrollja (hogy tartja a gyermek a fejét)

c. fejbőr - tisztaság, sérülések, hámlás, vérzések-véraláfutások, csomók, hegek

d. koponya - tapintsuk nyitva vannak-e a varatok, kutacsok, törések, dagadás

e. arc - szimmetria, mozgás, általános megjelenés. Keressünk szokatlan dagadast

f. sinusok - tapintsuk és kopogtassuk érzekenységre és dagadásra

3. Nyak

a. mozgási kitérések határai

b. nagyság, tapintsuk kapcsolt részeit

c. légcső

d. pajzsmirigy

e. nyaki nyirokcsomók

4. Szemek - nagyság, szimmetria, szín, mozgás-képeség, mélyebb strukturák (retina) megtekintése Fundus vizsgálásához ophthalmoscope kell

a. általános megtekintés

b. helyzetük és elrendezésük

(1) relativ helyzetük az arcon

(2) elhelyezésük szimmetriája

(3) a szemhéj-rések általános iránya

c. a külső strukturák megtekintése

(1) szemhéjak - szin, nagyság, mozgathatóság

(2) szempillák

(3) bulbaris (szemgolyóhoz tartozó) kötőhártya

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(4) sclera (ínhártya)

(5) cornea (szaruhártya)

(6) pupillák

d. belső strukturák

(1) az ophthalmoscope kezelése, használata

(2) előkesziteni a gyermeket

(3) a szemfenék (fundus) megvizsgálása

(a) vörös reflex (visszatükröződés)

(b) optic disc (látóidegfej)

(c) vérerek

(d) macula

5. Fülek

a. általános inspekció, helyzet, egymáshoz-fejhez való viszony

b. külső strukurák vizsgálata

(1) fűlkagyló-alakzata

(2) bőr felszin

(3) általános hygiene

(4) váladékozás a fülcsatornából

c. belső strukturák vizsgálata

(1) az otoscope használata

(2) a gyermek elhelyezése

(3) behatolás a fülcsatornába, az otoscope behelyezése

(4) fény reflex (vissza-verődés)

(5) csontos határvonalak

(6) tympanometer

6. Orr

a. külső strukturák inspekciója

(1) helyzet és irány

(2) szimmetria

(3) orrlukak tágulásának jelei

b. belső strukturák megtekintése

(1) a nyálkahártya bélés színe, duzzadása, váladék, szárazság vagy vérzés

(2) megtekinteni a turbinátusokat, választófalat (septum)

(3) szaglásérzék

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7. Száj és torok

a. ajkak-sérülések, elváltozások

b. belső strukturák

(1) szájüreg

(a) nyálkahártya

(b) lehellet szaga

(c) fogak

(d) íny

(e) nyelv

(f) kemény szájpadlás

(g) lágy szájpadlás

(h) uvula

(2) szájgarat

(a) mandulák

(b) hátsó garat

8. Mellkas

a. méret, alak, szimmetria, mozgás, mellek fejlettsége, csontalakulatok

b. csontos mellkas-bordák

c. sternum (szegycsont)

d. mellkasüreg

(1) nagyság

(2) alak

(3) szöglet

(4) szimmetria

(5) mozgás

(6) mellbimbók, mell fejlettsége

9. Tüdők

a. lebenyek, helyzetük

b. inspekció:

1. légzés

(a) gyakorisága

(b) ritmusa

(c) mélysége

(d) minősége

(e) a légzési hangok karaktere

(2) légzési tipusok Tábla 5

c. tapintás:

(1) vocális rezgés

(2) crepitáció (sercegés)

d. kopogtatás

e. hallgatózás

(1) puha sejtes légzés

(2) broncho-vesiculáris légzési hangok

(3) bronchiális légzés

(4) hiányzó vagy csökkent légzési hangok

(5) hangadással velejáró (a mellkason át hallott)

(a) suttogásos pectoriloquia

(b) bronchophonia

(c) egophonia (mekegésnek hangzik)

(6) járulékos hangok

(a) szörcsölő hangok

(i) fínom, közepes, hangos

(b) sipolás

(i) fütyülő-jellegű, hangzatos

(c) pleurális dörzszörej

10. Szív

a. általános kiértekelés - komprehenziv kiértekelése a pulzusnak, vérnyomásnak, légzés működésnek, és általános fizikai fejlettségnek és növekedésnek

b. inspekció - kiemelkedés, az apicális (szivcsúcs) pulzus lokalizálása

c. tapintás - érezzük a maximális szivcsúcslökés helyét, suhanó-zörej, pericardiális (szivburok) dörzszörejt

d. kopogtatás - külső határok meghatározása

e. hallgatozás - szívhangok eredete

f. megkülömböztetni normális szívhangokat

(1) minőség

(2) intenzitás

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(3) szaporaság

(4) ritmus

g. A szivhang szaporaság külömböző tipusai: Table 6

h. osztályozni a szívzörejek intenzitását

11. Has

a. inspekció

(1) alakzat

(2) nagyság és tónus

(3) bőr

(4) mozgás

(5) pulzálás

(6) köldök

(7) sérvek

(8) anális régió (tájék)

(a) fissurák (rependések)

(b) prolapsus (előesés)

(c) polypok

(d) bör lebenykék

b. hallgatózás: peristalsis, bélmozgás hangjai

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c. kopogtatás: máj, gyomor "gáz-hólyagja", mozgó tompulat (folyadék a hasüregben)

d. tapintás

(1) felületes

(a) érzékenység, izomtonus, felületes elváltozások, bőr-turgor

(b) érzékenység

(i) zsigeri

(ii) szervi-szomatikus

(iii) nyomás utáni elengedés ("rebound") vált ki fájdalmat (hashártyagyulladás lehet)

(c) mélytapintás - tapintani szerveket és nagyereket, találni masszákat és érzékenységet

(i) máj

(ii) lép

(iii) vesék

(iv) hólyag

(v) vakbél (caecum)

(vi) sigmoid

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(vii) aorta

(viii) femoralis pulzus

(ix) hasreflexek

12. Nemi szervek

a. férfi (fiu) nemiszervek

(1) inspekció - himvessző nagysága, makk és fityma, húgycső nyilás, herezacskó nagysága, színe, szőrzet eloszlás

(2) tapintás - identifikálni: heréket, mellékheréket, ondóvezeték, és ha van, lágyéksérvet

b. női (leány) nemiszervek

(1) inspekció és tapintás

(a) vulva, vagy szeméremtáj

(b) szőreloszlás

(c) clitoris (csikló)

(d) nagyajkak

(e) kisajkak

(f) húgycsőnyílás

(g) hüvelybemenet

(h) szűzhártya (hymen)

(i) Bartholin mirigyek

13. Hát és végtagok

a. gerinc: tartás-görbület; lordosis, kyphosis, scoliosis

b. hát: hajcsomó, gödrök, elszineződés, masszák, mozgásképesség

c. végtagok: szimmetria hosszban és nagyságban, számoljuk meg az ujjakat, lábujjakat, dobverőujjak, szederjesség (cyanosis) körömelváltozások, hygiene.

d. karok, lábak

(1) inspekció hőmérsékletre, színre, érzékenységre.

(2) 5 fő kritérium:

(a) fájdalom

(b) pulzus

(c) paresthesia, abnormális érzés, zsibbadás

(d) sápadtság

(e) bénulás

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(3) csontok alakját kiértékeljük: karika-láb (genu varum) X-láb (genu valgum), tibiális torzió

e. lábak

(1) plantáris reflex

(2) Babinski jel (dorsiflexiója a nagyujjnak és a többi lábujj szétterpesztése) normális csecsemőkorban, de egyéves kor után abnormális mikor a gyermek már tud járni.

(3) járás

(a) metatarsus varus

(b) befelé forduló tibia

(c) a combcsont nyakának előrefordulása

(d) széles nyomtávon való járás megmarad, jele lehet a kisagy egyensulyozási problémajának.

(e) olló-járás (spasztikus formája a cerebrális palsynak)

(f) kacsázó járás - gyermekenek csipőficama van

(4) izületek

(a) ki kell értékelni a kitérés lehetőségére

(b) tapintani melegség, érzékenység és dagadásra

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(5) izmok

(a) fejlettség

(i) alak és kontur - relaxált és összehúzott állapotban

(b) tónus

(i) sorvadás

(ii) túltengés (hypertrofia)

(c) erő

(i) ellenállás ellen tóljon vagy húzzon

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14. Neurológiai kiértékelés

a. viselkedés

(1) általános benyomás a gyermek szemelyiségéről érzelmi világáról, szociális interakciójárol és figyelme időtartamáról

(2) eszméleti állapot

(a) túl irritabilis

(b) hyperaktiv

(c) letargiás

(d) delirium

(e) stupor

(f) koma

Èrtékeljük ki az eszméleti állapotot megfigyelve hogy a gyermek hogyan reagál parancsoka, a neve emlitésére, és hogy válaszol tűszúrásra, vagy egyéb fájdalmas stimulusra

b. kognitiv-észlelési fejlettség, legjobb erre formális szűrőtesztet használni, pl. DDST

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c. motor működés

(1) motor képesség kiértékelése elsősorban magába vonja az akaratlagos izomzat kontrakcióját és a korra jellemző fejlődési mérföldkövek eléresét durva és finom motor ügyességre

(2) izomzat fejlettsége - állapitsuk meg izomtömeget, tónust, erőt, és abnormális akaratlan mozgást amint fel van sorolva

(3) további jelei lehetséges neurologiai károsodásnak

(a) túlhajlékonyság (hyperflexibilitás)

(b) sebes pislogás

(c) bólogatás

(d) állandóan a száj előtt tartott kéz

(e) csecsemőben erősen aszimetrikus vagy ernyedt petyhüdt tartás

d. érzés működés

(1) kiértékelni az agyidegek szempontjából-látás, hallás, periferiás érzés

(2) tapintási érzés érintetlensége

(3) érzés diszkrimináció

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(4) hallási tesztek

(a) audiometria

(b) akusztikus impedancia vagy dobhártya feszültség mérese

(c) megütközés reflexe

(d) hang lokalizálása

(e) öt-játék teszt

(f) Rinné teszt - légvezetés

(g) Weber teszt - csontvezetés

(5) látás vizsgálat

(a) fényérzés

(b) látásélesség: Snellen E tábla

(c) DEST (Denver szem szűrő vizsga)

(d) perifériás látás, látóterek

(e) szinlátás

(i) Ishihara teszt

(ii) Hardy-Rand-Rittler (HRR)

e. kisagy funkció vizsgálata

(1) kisagy (cerebellum) főleg az egyensúlyt és koordinációt ellenőrzi

(2) kisagyi működés jórésze benn-foglaltatik a gyermek tartásának, testmozgásának, járásának, és finom valamint durvább motor funkcioknak megfigyelésében

(3) cerebelláris funkciók, melyeket mint játékokat meg lehet vizsgálni

(a) ujjat-az-orrhoz teszt

(b) sarkot végighúzni a sípcsonton teszt

(c) Romberg teszt

(4) koordinációt lehet kiértékelni bármilyen gyors ismételt mozgás végrehajtatásával

f. reflexek

(1) reflexek vizsgálata a neurologiai kiértékelés fontos része

(2) primitiv reflexek fennmaradása, reflexhiány, vagy mély inreflexek hyperaktivitasa rendszerint cerebrális inzultus eredménye

(3) felületes reflexek: hasi, cremaster, anális és plantaris

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(4) mély ínreflexek (DRT-ok)

(5) ha meningitisre van gyanu, használjuk

(a) Kernig jelet

(b) Brudzinski jelet

g. agyidegek - Tábla 4

h. "puha" jelek

(1) egy jelenség, mely normális fiatal gyermekben, de a normális fejlődes során el kellene tünnie....fejlődési lemaradást jelent, vagy az érző vagy motor szisztéma differenciálódásának hiányát.

(2) puha jelek listája

(a) rövid ideig tud odafigyelni

(b) szokatlan testmozdulatok, melyek jelzik a hiányos koordinációt és pozició-érzést

(c) túlzott, sokáig tartó és haszonnélküli mozdulatok (hyperaktivitás)

(d) hypoaktivitás

(e) impulzivság

(f) emócionális labilitás

(g) szórakozottság

(h) kezesség nincs meghatározva

(i) nyelv és kifejezési problémák

(j) percepciós hiányosságok (tér, forma, mozgás és idő)

(k) problémák tanulással, különösen olvasással, irással és számtannal

Tabla 1.

Korra speciális irányvonalak gyermekkori fizikális vizsgálatra

KOR	POZICIÓ	FOLYTATÓLAGOS LÉPÉSEK	ELŐKÉSZÜLET
Csecsemő	Mielőtt egyedül tud ülni: hanyatt vagy hason fekve, legjobb ha szülő ölében; 4-6 hónapos kor előtt: fel lehet rakni a vizsgáló asztalra Ha már tud egyedül ülni legjobb ha a szülő ölében ül ha csak lehetséges. Ha asztalra helyezzük, úgy ültessük, hogy jól láthassa közben a szülőt	Ha nyugodt, hallgassuk meg a szivet, tüdőt, hasat Regisztráljuk szivverést és légzési szaporaságot Tapintsuk és kopogtassuk ugyanazokat a terűleteket Fejtől láb irányba haladjunk Fájdalmas beavatkozást hagyjuk utoljára (szemek, fülek, száj mialatt sír, rectális hőmérséklet Váltsunk ki reflexet amikor a megfelelő testrészhez érünk Moro reflexet hagyjuk utoljára	Teljesen vetkőztessük le, ha szobahőmérséklet megengedi. Fiun hagyjuk rajta a pelenkát. Nyerjünk kooperációt figyelem elterelésével, fényes tárgyakkal, csörgővel, beszéddel. Mosolyogjunk csecsemőre: használjunk lágy, gyengéd hangot. Nyugtassunk cuclis üveggel, cukros vizzel vagy etetéssel. Kérjük szülőt hogy segitsen lefogni mikor vizsgáljuk a füleket, szájat. Kerüljünk el hirtelen, váratlan mozdulatokat.

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Korra speciális irányvonalak gyermekkori fizikális vizsgálatra

KOR	POZICIÓ	FOLYTATÓLAGOS LÉPÉSEK	ELŐKÉSZÜLET
Kisgyerek	Ülve vagy állva a szülő ölében vagy mellette	Testrészeket játékon keresztül vizsgáljuk: "számoljunk ujjakat" "csiklandozzunk lábujjakat". Minimális fizikai kontaktust alkalmazzunk. Műszereket lassan hozzuk akcióba Hallgatózzunk, kopogtassunk, tapintsunk	Szülő vetkőztesse a gyermeket (külső ruhát) Alsónemüt vegyük le, mikor azt a testrészt vizsgáljuk. Hagyjuk, hogy megnézze a műszereket: a műszerek működését bemutatni rendszerint hatástalan. Ha a gyerek nem kooperál, a procedurákat gyorsan hajtsuk végre. Fogjuk le ha kell, kérjünk szülői segitséget. Ha kooperál, beszéljunk a vizsgálatról, rövid mondatokat használjunk. Dicsérjük meg kooperálásért.

Tabla 1.

Korra speciális irányvonalak gyermekkori fizikális vizsgálatra

KOR	POZICIÓ	FOLYAMATOS LÉPÉSEK	ELŐKÉSZITÉS
Iskola előtti gyermek	Kivánatosabb állni vagy ülni Leginkább kooperál hason vagy hanyatt fekve Szülö legyen közel	Ha kooperál haladjunk fejtől láb felé Ha nem kooperál, kezeljük mint koránál fiatalabbat	Kérjük, hogy sajátmaga vetkőzzék le. Ha szemérmes, engedjük, hogy alsónemüt fenntartsa. Ajánljuk műszereket megnézésre. Röviden demonstráljuk a műszerek használatát (kipróbálhatjuk szülőn) Találjunk ki "történetet" az eljárásról: "megnézem, milyen erősek az izmaid" vagy "megölelem a karodat egy speciális szövettel" (vérnyomásmérés) Használjuk a papír-baba technikát Ha lehet, engedjünk választékot Várjuk el a kooperációt; használjunk pozitiv mondatokat. "Nyisd ki a szádat"

Tabla 1.

Korra speciális irányvonalak gyermekkori fizikális vizsgálatra

KOR	POZICIÓ	FOLYAMATOS LÉPÉSEK	ELŐKÉSZITÉS
Iskolás gyermek	Legszivesebben ül Kooperativ legtöbb pozicióban Fiatalabb korban kivánja szülő jelenlétét Idősebbek inkább akarnak privát vizsgálatot	Fejtől-láb irányba haladjunk. Nemi szervek vizsgálatát hagyjuk utoljára Tiszteljük a privát vizsgálat igényét	Kérjük, hogy sajátmaga vetkőzzék, engedjük, hogy alsónemüt viseljen. Magyarázzuk meg a felszerelés célját. pl. otoscope-pal dobhártyát nézünk, mely a halláshoz szükséges Tanitsuk testműködéseket és a test jó karbantartását

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Tabla 1. **Korra speciális irányvonalak gyermekkori fizikális vizsgálatra**

KOR	POZICIÓ	FOLYAMATOS LÉPÉSEK	ELŐKÉSZITÉS
Serdülőkor	Ugyanaz mint iskolás gyermeknek. Ajánljuk szülő jelenlétét, a gyermek kivánsága szerint	Ugyanaz mint idősebb iskolásnál	Engedjük meg, hogy privát vetkőzzék le Adjunk lepelt Csak a megvizsgálandó területet tárjuk fel Tiszteljük a privát korülmények szükségességét. Magyarázzuk meg mit találunk vizsgálatkor: "Az izmaid szilárdak és erősek". Tárgyilagosan kommentáljunk szexuális fejlődésről: A melleid fejlődnek, ahogy kell" Hangsúlyozzuk a kifejlődés normális voltát. Nemi szerveket vizsgáljuk meg mint többi testrészt: lehet a végére hagyni. Használni lehet tükröt a nemi szervek vizsgálatánál hogy a gyermek láthassa a megvizsgált területet és tanulhasson személyes anatomiájáról.

Tabla 2 Kopogtatási hangok definiciója

Kopogtatási hangok	Példák
HANGOK *	
Intenzitás- a hangok amplitudója vagy hangossága	Hangos kopogtatási hang - az üresebb, levegővel telt terekből, mint pl. a tüdők Halkabb hangok: szolidabb masszák produkálják kopogtatáskor, pl. szív
Hangmagasság - a hanghullámok (rezgések száma másodpercenként, minél több és gyakoribb rezgés, annál magasabb a hang, kevesebb rezgés: alacsonyabb (mélyebb) hang	Alacsony hangmagasság - léggel telt tüdők Magasabb hangok - tüdőszövet konszolidációja
Tartam - mennyi ideig tartanak a rezgések	Hosszabb tartam: tüdő (normális) Rövidebb tartam, sürübb állományu szerv:sziv
Minőség, hangszín - szubjektíve van kiértékelve, függ a hang eredetétől	Mint ahogy ugyanazon magasságu hang külömbözik hangszínben, ha más hangszerekből jön, úgy egyenlő hangosságu és magasságu hangok is külömböznek egymástól hangszínben ha más szervből erednek, pl. tüdők és szív

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Tabla 2 Kopogtatási hangok definiciója

Kopogtatási hangok	Példák
Megjegyzés	
Rezonancia - tiszta, zavartalan hang, alacsony magasság, hosszu tartam, aránylag hangos (könnyen hallható)	Normális tüdők
"Dobos" hang: tiszta, zavartalan, magasabb mint a rezonáns hang, gazdag felhangokban és hosszú tartamu	"Dobos" hangot lehet produkálni ha gyengéden kopogtatjuk léggel telt arcot hasonló hangot kapunk ha léggel telt gyomrot kopogtatunk

Tabla 2 Kopogtatási hangok definiciója

Kopogtatási hangok	Példák
Hyperrezonancia - féluton rezonáns és dobos között alacsonyabb mint normális rezonancia, magas intenzitásu, hosszu tartamu	Általában csökkent denzitást (anyag sűrüséget) jelent, pl. több mint normális levegő, vagy csökkent szövet; legtöbbször kóros pl. pneumothorax vagy asztma
Tompaság - magas frequenciáju, rövid tartamu, puha (alacsony intenzitásu) és dórömbölő	Magasabb anyagsűrüséget (denzitást) és szolidságot jelent, pl. sziv
Laposság - teljes tompaság, magas hang, nagyon rövid, nem zenei a kvalitásában	Szolid szövet, pl. comb.

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*Ugyanazokat a kifejezéseket használjuk bármilyen más hang leirására, és a hallgatózáskor nyert hangok kiertékelésére is használjuk

Tábla 3 Általános irányvonalak gyermekkori fizikai növekedésben

Kor	Súly *	Magasság (hossz) *
Csecsemők (születéstől - 6 hónapos korig)	Heti súlygyarapodás: 140-200 gm Születési súly megduplázódik az első 6 hónap végére (egyesek szerint mar 3.8 hónap utan)	Havi gyarapodás: 2.5 cm (1 inch)
6-12 hónaposak	Heti súlygyarapodás 85-140 gm Születési súly megháromszorozódik az első év végére	Havi gyarapodás: 1.25 cm Első év végére kb. 50 % - s növekedés a születési hosszhoz képest
Kisgyerekek	Születési súly megnégyszereződik 2½ évre	2 éves korban magasság kb. 50% - a várhato felnőtt magasságnak 2ik évben kb. 12 cm 3ik évben kb 6-8 cm növekedes
Óvodások	Évi súlygyarapodás 2-3 kg	Születési hossz megduplázodik 4 éves korra. Évi novekedes 6-8 cm
Iskolások	Évi súlygyarapodás 2-3 kg	Évi növekedés 7 éves kor után 5 cm. Születési hossz háromszorosra nő 13 éves korra
Pubertással járó hirtelen növekedés Lányok 10-14 év kozott	Súlygyarapodás 7-25 kg Átlag: 17.5 kg	Magasság: 5-25 cm. növekedés kb. 95% a felnőtt magasságnak elérhető a menarche, vagy 13 éves csontváz-korra. Átlag 2015 cm
Fiuk 11-16 év között	Súlygyarapodás 7-30 kg. Átlag 23.7 kg	Növekedés: 10-30 cm, 15 éves csontváz-korra kb 95% a felnőtt magasságnak el lesz érve. Átlag: 27.5 cm

* Az évenkénti hossz és súlygyarapodás minden korcsoport számára átlag, külömböző forrásokból

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Tabla 4. Agyidegek működésének kiértekelése

Ideg	Beidegzés eloszlása	Próba (teszt)
I. Olfactorius (szagló ideg (S)*	orrűregi nyálkahártya olfactorius része (fenn)	Csukott szemmel a gyermekkel szagoltatunk ismerős illatokat, mint kávét, alkoholt vattáról, egyéb szagokat. Az orrlyukakat külön kell tesztelni
II. Optic (látóideg) (S)	Recehártya (retina) pálcák és csapok	Vizsgáljuk fényérzést, látóélességet és normális discus opticust (látóideg fej)
III. Oculomotorius (M)*	Szemizmok	A gyermek kövessen egy tárgyat vagy fényforrást, de csak a szemeit mozgassa, ne forditsa a fejét
IV. Trochleáris (M)	Obliquus superior izom	A gyermek nézzen lefelé
V. Trigeminus (M, S)	Rágóizmok, az arc bőre és a fejbőr elülső ketharmada	A gyermek keményen harapjon aztán nyissa ki a száját. Tesztelni kell szimmetriát. A gyermek hunyja be szemét, észreveszi-e, hogy gyengéden megérintjuk a mandibuláris és maxilláris tájékot? Teszteljük cornea és pislogási reflexet a corneát nagyon könnyedén megérintve. (oldalról közeledjűnk a gyermekhez, hogy ne pislantson még mielőtt megérintjük a corneát)

Tabla 4. Agyidegek működésének kiértekelése - Continued

Ideg	Beidegzés eloszlása	Próba (teszt)
VI. Abducens (M)	Rectus laterális szemizom	A gyermek nézzen vizszintesen balra es jobbra.
VII. Faciális (M)	Orrüreg és könnymirigy, sublinguális és submandibuláris (submaxilláris) nyálmirigyek, mimikai arcizmok, és a nyelv elülső két-harmadán izérzés	A gyermek mosolyogjon, vágjon vicces arcokat. Ismerjen meg édes, savanyu és keserű ízeket. Az ízeket a kinyujtott nyelv elülső felszinére és oldalaira helyezzük; ha a gyermek visszahúzza nyelvét, az oldat le fog szivárogni a nyelv hátsó részeire.
VIII. Auditorius (hallóideg) (cohleáris, vagy vestibulocochleáris) (S)	Belső fül	Hallásvizsgálat; ügyeljünk egyensúlyvesztésre és szedülésre
IX. Glossopharyngeus ideg (M,S)	Pharynx (garat) nyelv, és a nyelv hátsó egyharmada izérzésre	Csiklandozzuk a hátsó garatfalat nyelvlappal: a gyermeknek öklendezni kell. Teszteljük ízérzést a nyelv hátsó egyharmadán
X. Vagus (M,S) (bolygóideg)	Gégeizmok, garatizmok a gyomor-béltraktus egyes szerveinek izmai, érző rostok a nyelvgyökből, szívből, tüdőből és a gyomor-béltraktus egyes szerveiből	Figyeljünk rekedtségre öklendező reflex jelenlétére, nyelőképességre. Ellenőrizzük, hogy az uvula (nyelvcsap) a középhelyzetben van-e. Ha nyelvlapoccal érintjük, felfelé és a stimulált oldal felé kell mozognia.

Tabla 4. Agyidegek működésének kiértékelése - Continued

Ideg	Beidegzés eloszlása	Próba (teszt)
XI. Accessorius (M)	Sternocleidomastoideus izom és a váll trapezius izma	A gyermek vonja meg vállait gyenge nyomás ellen. Helyezzük tenyerünket a gyermek vállára és forditsa fejét ellenállással szemben balra és jobbra. Figyeljük meg a szimmetriát és az erőt.
XII. Hypoglossus (M)	A nyelv izmai	A gyermek mozgassa nyelvét minden irányban. Dugja ki nyelvét amennyire csak tudja. Figyeljünk elhajlásra. Teszteljük a nyelvizmok erejét avval, hogy a nyelvlapocot a nyelv egyik oldalára helyezzük és a gyermeknek kell onnan a nyelvével eltolnia.

*S - sensory (érzö); M - motor

Tabla 5 Lélegzés külömböző formái
("pnea" magyar orvosi irodalomban gyakran "pnoe" (Görögből)

NÉV	LEIRÁS
Tachypnea	Szaporább mint normális
Bradypnea	Ritkább mint normális
Dyspnea	Nehéz légzés
Apnea	Légzés megszünése
Hyperpnea	Mélyebb légzés
Hypoventilláció	Sekély légzés, megzavart ritmussal
Hyperventilláció	Szaporább légzés és mélyebb
Kussmaul lélegzés	Hyperventilláció, légszomj, erőltett légzés legtöbbször diabetikus komában fordul elo, vagy respirációs acidozis más formáiban
Cheyne-Stokes lélegzés	Fokozatosan szaporább és mélyebb lélegzés, és periodikusan légzésszünet
Biot lélegzés	Hyperpnea váltakozik apneával (Hasonlit Cheyne Stokes-ra de mélység változatlan marad)
Fűrészelő (paradoxikus) legzés	A mellkas emelkedik mialatt a has besüpped

Table 6. Kulömböző szívverés és pulzus típusok

Név	Leirás
Tachycardia	Szapora pulzus
Bradycardia	Csökkent szaporaságu pulzus (lassú szívverés)
Pulsus alternans	Erős ütést gyenge ütés követi
Bigeminia	Párosával érezni a pulzus verést extrasystole miatt
Pulsus paradoxus	Belélegzéskor a pulzus ereje csökken
Sinus arrhythmia	Belegzéskor szaporább a pulzus, kilégzéskor gyérebb
Viz-kalapács, v. Corrigan pulzus	Különösen erőteljes pulzus-ütes, oka a széles "pulzus-nyomás" (szisztolés és diasztolés vérnyomás közötti külömbség nagy)
Dicrotic pulzus	Minden apicális szivhanggal két radialis pulzus jár
Vékony, elnyomható ("filiformis") pulzus	Szapora, gyenge pulzus mely megjelenik és eltünik

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GYERMEKKORI ROSSZINDULATU DAGANATOK: Áttekintés

Pamela L. Cummings R.N., B.S.N.

I. A probléma általános keretei

   A. Gyakoriság

   B. Halálozás

   C. Prognózis

   D. Összehasonlitás felnőtt rákkal

II. Kezelés fajtái

   A. Válogatott specialitásu "team" (összemüködő csapat)

   B. Családra központosult kezelés

III. Epidemiológia (járványtan)

   A. Környezeti tényezők

   B. A beteg saját tényezői

   C. Genetikus (veleszületett) tényezők)

   D. "Két csapás" elmélete

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IV. Gyermekkori malignus tumorok (angol összefogó szó: "cancer")

A. Leukémia

1. ALL (Akut lymphocytás leukémia)

a. Klinikai megjelenésforma
b. Diagnózis
c. Kezelés
d. Prognózis

2. ANLL (Akut nem-lymphocytás leukémia)

a. Klinikai megjelenésforma
b. Diagnózis
c. Kezelés
d. Prognózis

B. Központi idegrendszer (Agydaganatok)

1. Klinikai megjelenésforma
2. Diagnózis
3. Kezelés
4. Prognózis

C. Malignus lymphomák

1. Hodgkin kór

a. Klinikai megjelenésforma
b. Diagnózis
c. Kezelés
d. Prognózis

2. Nem-Hodgkin kóros lymphoma

a. Klinikai megjelenésforma
b. Diagnózis
c. Kezelés
d. Prognózis

D. Neuroblastoma

1. Klinikai megjelenésforma
2. Diagnózis
3. Kezelés
4. Prognózis

E. Wilms' daganat

1. Klinikai megjelenésforma
2. Diagnózis
3. Kezelés
4. Prognózis

F. Rhabdomyosarcoma

1. Klinikai megjelenésforma
2. Diagnózis
3. Kezelés
4. Prognózis

G. Csont daganatok

1. Ewing Sarcoma

a. Klinikai megjelenésforma
b. Diagnózis
c. Kezelés
d. Prognózis

2. Sarcoma osteogenicum

a. Klinikai megjelenésforma
b. Diagnózis
c. Kezelés
d. Prognózis

H. Retinoblastoma

1. Klinikai megjelenésforma
2. Diagnózis
3. Kezelés
4. Prognózis

V. Tényezők melyek hozzájárulnak jobb prognózishoz

A. Kombinációs kezelés (gyógyszerek)

B. Mutispecialitásos megközelitése a problémáknak

C. Részvétel országos tanulmányokban (analízisekben)

D. Támogató kezelés

1. Vér komponens terápia (pótlás)
2. hányás elleni kezelés
3. fertőző betegségek
4. Megjavitani a kezelés módozatait, végrehajtását

a. szerkezetek melyek intravénás megközelitést megkönnyitik
b. egészségügyi ellátás a közösségben
c. otthoni ápolás
d. orvos a közösségben
e. gondozó-otthon

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PEDIATRIC ONCOLOGY OVERVIEW
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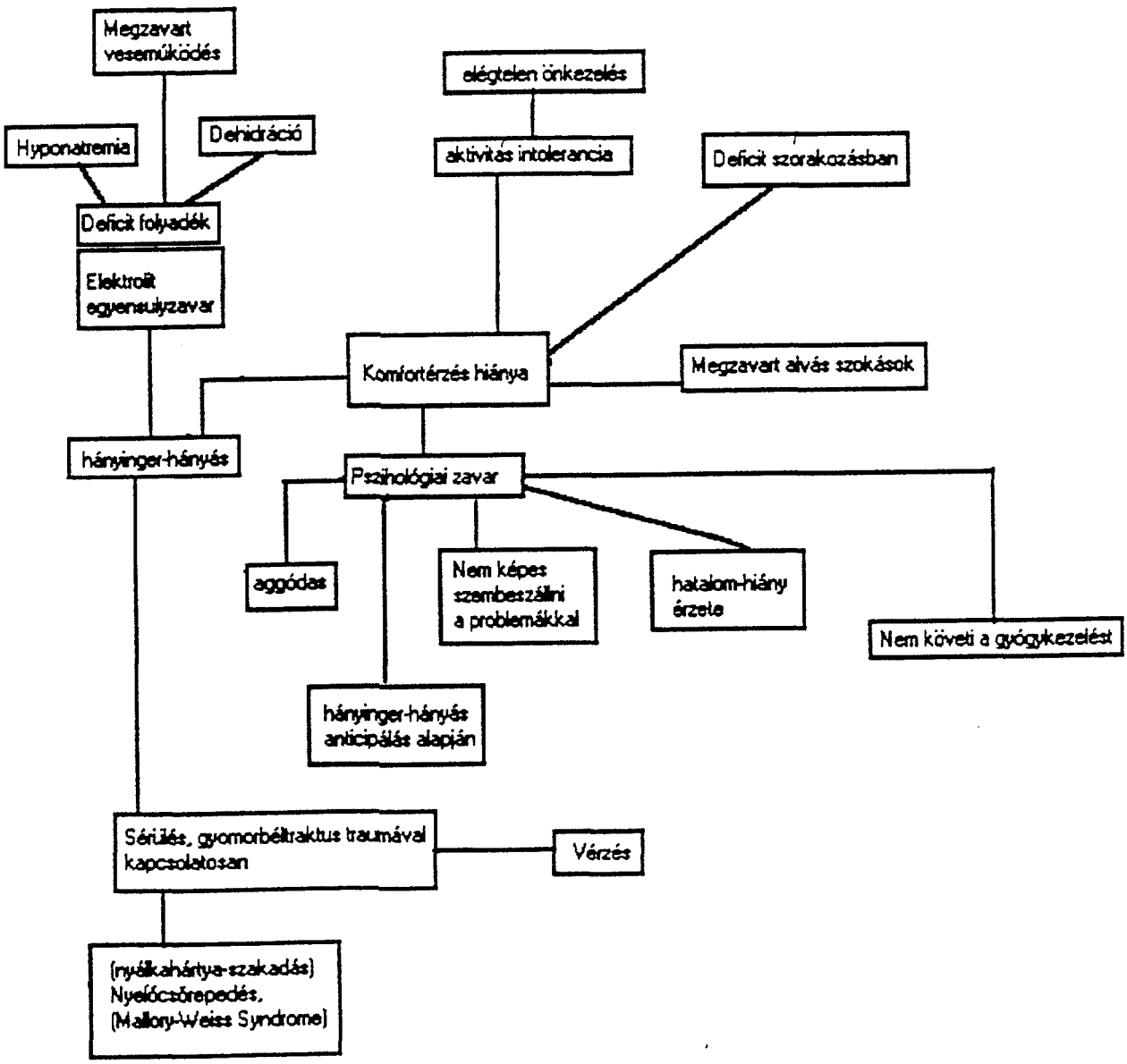
Lavonne Ridder, R.N., M.A.

Hányinger gyakori chemotherapia után es lehet akut (a gyógyszerelés közben vagy azonnal követve) szubakut (6-12 órával később), kései (2-3 nap mulva) vagy anticipált (egy bekondicionált reakció multbeli chemotherápia utáni hányingerre vagy hányásra alapozva). Fontos hogy hányinger és hányás kontrollálva legyenek mert komplikációk léphetnek fel mint mellékhatások. Ilyen komplikációk közé tartozik nyelőcső-fal kiszakadása, törések, hosszantartó étvágytalanság, alultápláltság, anyagcsere zavarok es folyadék veszteség.

Potenciális problémák betegekkel



(Kölcsönözve Barton-Burke(1991) Cancer chemotherapy: A nursing process approach Boston: Jones and Barlett kiadok, 92.old.)

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Meghatározások:

Hányinger: bizonytalan hullámzás érzet és tudatos szükségérzete a hányásnak

Hányás: aktuális eröteljes kiüritése a gyomortartalomnak szájon keresztül

Öklendezés: ritmusos összehúzodásai a légzési izomzatnak melyek fel és lefelé való mozgását okozzák a gyomortartalomnak a nyelőcsőbe.

Hányinger és hányás élettana:

1. A hányásközpont közel van elhelyezve (a nyultagyban) a reflexközpontokhoz melyek szabályozzák a kardiovasculáris és légzési funkciókat.E közeliség vezethet hányás közben az alábbiakra:

a. tachykardia
b. izzadás
c. gyengeség érzése, szédülés + hányinger
d. bradykardia
e. vérnyomásesés hányás közben
f. szapora és mély légzés

2. A hányásközpont stimulációt kap:

a. a gyomorbéltraktusból a vagus idegen keresztül ha késéssel ürül a gyomor, vagy gyomor-bél tágulás történik

b. agykéregből a hypothalamus által, ezt okozza aggódás, félelem, koponyaüregi nyomásfokozodás (ez a valószinü oka az anticipácios hányingernek és hányásnak)

c. vestibuláris összeköttések a labirint és vagus idegen keresztül, gyors vagy hirtelen helyzetváltoztatás esetében (nem játszik jelentös szerepet chemotherapia által okozott hányásban)

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d. perifériás pályák szimpatikus zsigeri afferens beidegzésen keresztul a gyomorbéltrakus, sziv és vesékből.Helyi irritáció vagy görcs tudja ezt stimulálni.

e. Chemoreceptoros ingerlékenységi zona, ezt stimulálják a keringésben lévő toxinok, elváltozott terhességi hormonok (vannak receptorok histaminra, dopaminra, acetylcholinra es opiátokra.) de tulajdonképpen az aktuális neurochemicalis élettana a chemotherapia által okozott hányingernek és hányásnak még nem teljesen ismeretes.

Antiemetikus (hányás-ellenes) kezelés elvei.

Edna Lavonne Ridder, R. N., M. A.

1. Adjunk a betegnek olyan antiemetikumot amely legjobban hat az adott helyzetben, az adott betegnél és okozatnál.

2. A leghatásosabb hányásellenes szerek azok, melyek több vagy az összes külömböző hányásra vezető pályákra hatnak.

3. Habár valószinű, hogy hányinger és hányás chemoterápia közben és után a gyógyszerekkel függ össze, fontos hogy más lehetséges okokat kizárjunk (bélelzárodás, peritonitis, agy metastasisok, gyógyszerek, mint pl. narkotikumok, folyadék és elektrolyt egyensuly, máj áttétek, fertőzés, sugárkezelés és urémia.

4. Vegyünk tekintetbe pszihogén tényezőket és probáljuk megelőzni ezeket első ciklus módszerekkel (hipnozis irányitott képzetekkel, szisztémás deszenzitizácio, progressziv izom-elernyesztés)

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5. A hányinger és hányás foka és tartama összefügghet a chemoterapiás gyógyszerrel, annak dózisával, gyakoriságával, az adminisztráció módszerével, és a gyógyszer, vagy annak metabolikus lebomlási termékeinek elhuzódó (késlekedő) kiválasztásával.

6. Gyakoroljunk pre-chemoterapiás kiértékelést, mely foglalja magába hydrációt, electrolyt státuszt (megjavitani ha nem megfelelő) és aggódási fokot (adjunk támogatást és fejezzünk ki együttérzést amilyen fokon szükséges.)

7. Adjunk antiemetikumokat hogy fedezze a szóbanforgó chemoterápias gyógyszertől elvárt hosszuságú hányinger hányás periódus tartamát.

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Hányásellenes kezelés

1. Kezdjük a hányásellenes szereket adni a chemoterápia megkezdése előtt, ugyhogy receptorokat hatásosan blokkolni lehessen, megelőzve hányingert és hányást azáltal hogy a hányásellenes szerek vér szintjét előre felépitjük.

2. Az adagolás időbeosztása kapcsolatban legyen a gyógyszer adminisztráció módjával

3. Adjuk e gyógyszereket szabályos időközökben 24 óráig, úgy hogy egy mérsékelttől magas szintig tudjuk tartani a hányásellenes hatást.

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Chemotherapiás orvosságok hányástokozó potenciálja.

Magas százalékos előfordulás (tobb mint 80%)	Hányáselleni rendszabályok
mechlorethamine (nitrogen mustard) decarbazine (DTC) cisplatin (platinol) Mitomycin C BCNU, CCNU nagy adag cyclophosphamide nagy adag methotrexate nagy adag cytosine arabinoside	Aggressziv kombinációja a hányásellenes gyógyszereknek, nagy adag phenothiazine vagy odansetron, dexamethasonenal; Lorazepam vagy THC (Tetrahydrocannabinol)

Mérsékelt százalékos előfordulás (50%)	
doxorubicin (Adriamycin) daunorubicin (Daunomycin) cyclophosphamide (Cytoxan) ifosfamide dactinomycin (Actinomycin D) mitoxantrone procarbizine etoposide hexamethylmamine	Mérsékelten aggressziv gyógykezelés intravénás odnasetron, phenothiazinnal

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Alacsony százalékos elöfordulás (kevesebb mint 25%)

5-fluorouracil (5-FU)
methotrexate
bleomycin
cytosine arabinoside
(Ara-C)
melphalan
vincristine
hydroxyurea
etoposide

thiothepa
thioguanine
tamoxifen
chlorambucil
L-asparaginase
vinblastine
teniposide
6-mercaptopurine

Phenothiazinok es odnasetron

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ANTIEMETICS

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Fertőzés Betegben Aki Daganatellenes Kezelés Alatt Van

Tribhawan S. Vats, MD
Pamela L. Cummings, R.N., B.S.N.

I. Daganat-kezelés lényeges pontjai

   A. Orvosi kezelés
   B. Támogató ápoló kezelés

II. Fertőzés okai

   A. Maga az alapbetegség
   B. Az alapbetegség kezelése
   C. Mindakettő legyengiti a beteg ellenállását

III. Beteg legyengült védekezéssel

   A. A fertőzés behatol a legyengűlt bőr és nyálkahártya gátjain keresztül

   B. Phagocyta védelem

      1. Neutrofilek
      2. Monocyták

         a. Makrofagok

   C. A celluláris és humorális immunitás zavarai

   D. Splenektomia (a lép eltávolitása)

   E. Legyengült tápláltsági stádium

   F. Microbiális flóra behatolása és megtelepedése

   G. A kezelés intenzitási foka

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IV. Láz es neutropénia

A. 3 38 fokos láz leolvasása 24 órán belül

B. Egy kiugrás 38.5 vagy felette

C. 1000/mm^3 abszolut neutrofil szám a betegben

D. Abszolut neutrofil szám

E. Abszolut neutrofil szám (ANS)

F. Az ANS kiszámitása

V. Kompromittált beteg lázzal

A. Neutrofil szám megállapitása

B. A fertőzés jellege és a kórokozó identifikálása

C. A beteg fogékonysága

D. Diagnosztikus kiértékelés

E. Empirikus antibiotikus kezelés - cephalosporin + aminoglycoside

VI. A lázas neutropéniás beteg kiértékelése

A. Anamnézis és pontos fizikai vizsaálat

B. Két vértenyésztés bakteriumokra és gombákra

C. Ha van centrális vénás katéter, abból is kulturát venni

D. Kulturát az orrból, torokból és vizeletből

E. Széklet kultura baktérium, virus, gomba és Clostridiumokra

F. Mellkasröntgen

G. Sinus röntgen

H. Teljes vérsejtvizsgálat, serum transaminase, elektrolitok, Vér urea nitrogen (BUN) és creatinin

I. Ha bőrelváltozás van aspiráció és kimetszés (biopszia)

VII. Empirikus kezelés

A. Monoterápia (Ceftazidin)

B. Antibiotikum kombináció (Ceftazidin, Tobramycin)

C. Vancomycint rögtön kezdettől adunk ha betegnek bentrögzitett katétere van.

VIII. Láz és neutropénia 72 óra utan (he beteg kapott antibiotikus kezelést)

A. <u>Okok</u>

1. Nem-bakteriális fertőzés
2. Gyógyszerrezistens fertőzés
3. Másodlagos szuperinfekció
4. Nem adequát koncentrácioja az antibiotikumoknak
5. Ritka kórokozók

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B. Kiértékelés

1. Megismételni vér és portális (fertőzés behatolási területe) kulturákat

2. Megismételni mellkas és sinus röntgent ha javallt

3. Megvizsgálni a katéter behelyezési pontját es környező szöveteket

4. Leellenőrizni korábbi kulturákat (kinőtt-e valami?)

5. Klinikai kiértékelése a betegnek

IX. Specifikus fertőzések kezelése

Bacteriális fertőzés

A. Kórokozók

1. Gram negativ pl. Pseudomonas, Klebsiella, E. coli

2. Gram pozitiv pl. Staphylococcus epidermidis, hemolytic streptococcus és diphtheroidok

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X. Standard antibiotikus kezelés

A. Tobramycin 7.5 mg/kg/naponta intravénás minden 8 órában

B. Fortaz 150 mg/kg/naponta intravénásan minden 8 órában

C. Oxacillin 200 mg/kg/naponta intravénásan minden 8 órában

D. Clindamycin 40 mg/kg/naponta intravénásan minden 6 órában

E. Vancomycin 40 mg/kg/naponta intravénásan minden 6 órában

Mindig le kell ellenőrizni legmagasabb és átlag nivót hogy a dózist ehhez szabhassuk

XI. Bakteriális fertőzés profilaxisa

A. Orális nem felszivódó antibiotikumok

B. Trimethoprim Sulfamethoxazole

C. Az antibiotikumok quinolon csoportja

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XII. Virusfertőzések

Bárányhimlő (Varicella)

Herpes zoster

Cytomegalovirus

Epstein Barr virus

A. Bárányhimlő (varicella)

1. Gyakran terjed belső szervekre
2. Előfordulhat súlyos tüdőgyulladás, encephalitis és máj károsodás
3. Súlyosabb betegekben akik kemoterápián vannak és lymphopéniájuk van (560/mm^3 alatt)

B. Herpes Zoster (zona)

1. Rosszabb a morbiditás mint a mortalitás
2. Több dermatomát érinthet
3. Gyakran van idegrendszeri komplikáció és tünetek
4. Gyakoribb betegekben akiknek Hodgkin kórjuk van és acyclovirral kezelik

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C. Cytomegalovirus

1. Okozhatja vérátömlesztés, szervátültetés vagy latens virus reaktiválódása
2. Diagnosztizálni lehet Igm immunofluorescens antitest titerrel
3. Multiszisztémás betegséget okozhat
4. Kezelés legsikeresebb intravénás gamma globulinnal és gancyclovirrel

XIII. Gombás fertőzések

A. Gombás fertőzések

1. Candida albicans
2. Candida glabrata
3. Aspergillosis
4. Cryptococcosis
5. Histoplasmosis

B. Gombás fertózések

1. Kezelés

a. Amphotericin B.

(1) 0.2 mg/kg/naponta kezdeti adagnak, emelni 0.7-1.0 mg/kg/naponta adagra

(2) kezelés teljes tartama 2-8 hét

b. Prophylaxis

(1) Nystatin

(2) Ketaconezole

(3) Fluconozole

XIV. Egyéb fertőzések

Pneumocystis Carinii pneumonia

1. Rendszerint remisszió stádiumában jelentkezik

2. Hirtelen fellépő légzési nehézségek

3. Tachypnoe, hamuszürke szin

4. Tüdókben többszörös infiltrátumok

5. Tüdők zörej nélkül

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6. Diagnózis tüdőbiopsziával, tüdő aspirátumból vagy klinikailag

7. Kezelés TMP-2 és SMZ 100 mg/kg/naponta elosztva minden 6 órára intravénásan

8. Ha nincs javulás, pentamidin 4 mg/kg/naponta, intravénásan 10-14 napig.

XV. "Védett környezet" ("burokban élni" hogy fertőzés ne érhesse a beteget)

A. Több kiadás

B. Pszihologiai trauma

C. Hasznossága nincs bizonyitva

D. Neutropenia a legfontosabb javallata

Kémiai szerek és besugárzás okozta stomatitis
Pamela L. Cummings, R.N., B.S.N.

I. Bevezetés

A. Előfordulási százalék összes kezelt betegből

B. Meghatározás

1. stomatitis

2. szájszárazság, kiszáradás

C. Okozó tényezők és következményeik

1. fej és nyak besugárzás (Tabla 7)

a. nyálmirigyek működészavara

b. gyakoribb foggyökér-szuvasodás

c. ízérzés romlása, elvesztése

d. szájonbelüli vérzések

2. Nyálkahártya-toxikus kémiai szerek

a. szisztémás bakteriális fertőzések

b. növekszik a szájonbelüli elvátozások lehetősége

c. rontja a táplálkozást, étvágyat

d. terápia felfüggesztését indokolhatja

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II. A probléma megállapitása

A. fizikai jellegzetességek

B. a beteg szubjektív közlései (szájérzés)

1. Érzés a szájban (Tabla 7)

C. vizsgálati megállapítás

1. Orális kiértékelés (Tabla 7)

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III. Kezelés (Tabla 8)

A. Irányítás a megelőzésre

1. Kemoterápiás kezelés előtti teendők

a. onkológus-fogszakorvosi vizsgálat

b. szájhigiéne kialakitása a betegben

c. szájegészségügyi protokoll készítése

B. Módozatok a kezelésre

1. fájdalomcsillapítás

2. helyi alkalmazás

3. gombaellenes szerek

4. szájvérzést megelőző ill. mérséklő szerek

5. szerek szájszárazság ellen

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Tabla 7

Útmutató az orális vizsgálathoz (1-4 ig romló)				
	(1)	(2)	(3)	(4)
Ajak	Sima, puha	egyenetlenül száraz lehet pörkös	dagadt száraz száraz lehet hólyag	száraz repedezett vérző fekélyes
Nyálkahártya szájpadlás garat	rózsaszin nedves lepedék nélkül	vörös, ödémás enyhén száraz égő	vörös, száraz fekélyes lepedékes	nagyon vörös gyulladt fekélyes
Íny	rózsaszín nedves lepedék nélkül	halvány, enyhén száraz, vörös, hólyagos	vörös, fényes, ödémás hólyagos	vörös, fényes, fekélyes helyenként vérző
Nyál	vékony vízszerű	bővebb mennyiség	csökkent mennyiség	vastag, sűrű, nyúlós, viszkózus
Nyelési képesség	probléma nélkül	nehezitett evés, nyelés	fájdalmas evés, nyelés	evés-nyelés képtelenség
Diétá	normális folyadék és rágás szükséges			
Karbantartás szájhigiéne, evés	önálló	biztatni kell	segítségre szorul	teljesen másokra szorul

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Tabla 7

A beteg érzései szerinti szájállapot (1-4 ig romló)				
	(1)	(2)	(3)	(4)
Ajak	normál	enyhén száraz	száraz, ég, főleg a szájzug	erősen repedezett, ég nyitásra fáj
ínyállapot	normál	érzékeny de alig észrevehető	érzékeny zavaró	állandó fájdalomtudatot okoz
Nyálmennyiség	normál	több nyál	kevesebb nyál	szájszárazság, sűrű, nyúlós nyál
ízérés	változatlan	változó	smminek nincs szokott íze	nincs ízérzés
Evés, étvágy	rendben	nehéz nyelés szájszárazság miatt	fűszeres étel fogyasztása csípő érzést okoz	rágás-és nyelés képtelenség a fájdalom miatt

Tabla 8.

HELYI KEZELÉS SPECIFIKUS SZÁJÜREGI PROBLÉMÁKRA

PROBLÉMA	KEZELÉS	HASZNÁLATI MÓD
Lokalizált másodlagos ajakfertőzés	Neosporin	A szájkörüli elváltozásra alkalmazni 2-5 szor naponta az elváltozás súlyosságától függően
Fogszuvasodás megelőzése mely xerostomia kovetkezménye	savanyitott fluorid öblögetés	5-10 cc-vel naponta öblögetni 1 percig
	Semleges fluorid öblögetés	Nem lenyelni! 5-10 cc-vel naponta 1 percig öblögetés. Visszatérni a savanyitott fluoridra ha nyálka visszáter
<u>GOMBAELLENES GYÓGYSZEREK</u>		
Szájüregi candida fertőzés megelőzése és gyógyitása	Nystatin orális suspensió	Öblögetni és lenyelni 300.000 egységet 3-4x naponta Ha beteg nem tűri a nyelést, csak öblögetni

Tabla 8

PROBLÉMA	KEZELÉS	HASZNÁLATI MÓD
	Clotrimazole troche 10	Feloldani egy tablettát 5 X naponta. Clotrimazol profilaktikus hatasa candida fertőzés megelőzésére nem lett még kielégitően tanulmányozva
Candidiázis kezelése műfogsor alatt és szájszögletben (ajak-szöglet)	Mycolog kenőcs	2-3 X naponta alkalmazni az érintett területre, vagy müfogsor alá helyezni
Nyálkahártyagyulladás enyhitése	Xylocaine 25% viscózus oldat Dyclonine hydrochloride 0.5% vagy 1 oldat Benadryl es Kopectate oldat keverek (50% mindket tőból)	15 cc öblités maximum 30 másodperc minden 3 órában. Ki kell köpni
Nyálkahártyagyulladás (lokalizált) enyhitése	Benzocaine orabase kenőcsben	Az érintett területre (előbb leszáritani) tenni 2-3 óránkent. Nem szabad használni ha fertőzés van jelen

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Tabla 8

PROBLÉMÁK	GYÓGYKEZELÉS	HASZNÁLATI MÓD
HELYI VÉRZÉS KONTROLLÁLÁSA		
Iny	Helyi alkalmazásu thrombin oldat	Géz szivaccsal alkalmazni az érintett területre és ott tartani nyomás alatt 3 percig Nem szabad eltávolitani alvadékot ami már alakult.
Nyálkahártya felszin vérzés	Microfibrillaris kollagén	Száraz gézszivaccsal alkalmazni 1 től 5 percig Ne használjuk nyálkahártya incizió zárási vonalára
XEROSTOMIA (Szájkiszáradás) Nyál-helyellesitők Száj-nedvesitok	Szintertikus nyál rá-spriccelés	Annyit spriccelni amennyi a xerostomia enyhitésere kell
Konyhasót is lehet használni	Xerolube	Öblögetni ahogy szükséges a xerostomia ellen

* Fluoride gelek előgyárott tálon ajánlatosak
+ Savanyitott fluoridek ellenjavalltak ha betegnek porcellán műfogia vannak
DeVita, VT, és társai: Cancer. Principles and Practice of Oncology. Philadelphia: Lipincott, 2ik kiadás, 2dik kötet, 1985: 2017

VÉNÁS KATÉTEREK

Pamela L. Cummings, R.N., B.S.N.

I. Katéter tipusok áttekintése, anatomiai helyzet szerint

A. Vénás katéterek

1. Rövid lejáratu vénás katéterek

2. Hosszú lejáratu venás katéterek

B. Artériás katéterek

C. Intraperitoneális katéterek

D. Epidurális katéterek

II. Vénás katéterek

A. Typusok

1. Rövid lejáratu vénás katéterek szubkután alagut nélkül

a. Tulajdonságok

(1) anyag

(2) kis kaliber (rendszerint 15 kaliber belső átmérő) gyermekgyógyaszati kaliber/ 22 átmérő

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(3) helyhez varrva

(4) Radio-opaque

b. Perkután helyezés

(1) perifériásan a vena basilicán át a könyökhajlásban

(2) centrálisan a véna subclavia vagy jugularison keresztül

(3) egyéb

2. Hosszulejáratu vénás katéterek szubkutan alaguton át helyezve.

a. Tulajdonságok

(1) anyag

(2) átmérő

(a) legkisebb lumennal

(b) legnagyobb lumennal

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(3) jellegzetességek

(a) szimpla lumen

(b) dupla lumen

(c) tripla lumen

(d) pediatric (gyermekgyógyászati)

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(4) Dacron manzsetta

(a) lehetővé teszi hogy a bőralatti kötőszövetbe beágyazzák

(b) lehetővé teszi a katéter rögzitését

(c) minimumra csökkenti a felszálló fertőzés veszélyét

b. Hová helyezni?

(1) nagy véna

(a) cephalica

(b) jugularis interna

(c) subclavia

(d) femoralis

(2) a katéter vége épp a jobb pitvar fölött nyugodjék (ha a véna femoralisba helyezik, a katéter vége nem mindig ér a jobb pitvarba.)

(3) A katéter a bőralatti kötőszövetben egy alagutban lesz vezetve egy kijárathoz, rendszerint a mellkasfalon.

B. Klinikai javallatok

1. Rövidlejáratu vénás kateterek

a. rővidlejáratu tx i kemoterápia (45-60 nap)

b. rővidlejáratu infuzio hólyaghúzo kemoterápiás szerekhez

c. bentfekvő és járobeteg kemoterápia

d. egyetlen adag (bolus) kemoterápia injekció

e. rövid túlélés várása

f. egyéb

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2. Hosszulejáratu vénás katéterek

   a. vérlevevés

   b. csontvelő átültetés

   c. leukémiás betegek

   d. rövid vagy hosszulejáratu infúzio hólyaghúzó és nem-hólyaghúző kemoterápiája

   e. bentfekvő és jaróbetegek kemoterápiája

   f. teljes parenterális táplálás

   g. antibiotikus terápia

   h. járulékos fenntartó terápia

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C. Betegkiértékelés / kiválasztás kritériumai

1. Alacsony prioritású betegek vénás katéterre

   a. ritka szükségesség vénás gyógyszerelésre

   b. rővid lejáratu kezelés

   c. nem túl gyakori injekciók szűkségesek

   d. nem hólyaghuzó, nem ingerlő gyógyszerek

   e. nem volt korábban intravénás terápia

   f. jó (könnyen elérhető és használható) vénák vannak

   g. a beteg nem akar vénás katétert

   h. egyebek

2. Magas prioritású betegek vénás katéterezésre

   a. korlátolt megfelelő vénák

   b. gyakori szükség vénás adagolásra

   c. hosszulejáratu, kiszámithatlan időtartamu kezelési időszak

   d. állandó (folyamatos) infúziós kemoterápia

   e. otthoni kemoterápia-infúzió

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f. hólyaghúzó, ingerlő gyógyszerek

g. betegnek vénás trombózisa, vagy hegesedése van korábbi kezelésből

h. beteg kiván vénás katétert

i. van egyén aki gondját viseli a betegnek (sajátmaga vagy családtag)

j. egyebek

D. A kezelés elvei.

1. Bevezetni a rendszert (a katéter helyezése)

   a. aszeptikus technika

   b. hosszúlejáratu katétereket leszoritani

2. fenntartani a rendszer átjárhatoságat

   a. átöblités

   b. pozitív nyomás

   c. heparinizáció

3. kijárati nyilás gondozása

4. cserélni az injekciós kupakot

E. Komolyabb komplikációk (szövődmények)

1. Katéter-okozta károsodás, sérülés

   a. megállapitás

   b. megelőzés

   c. kezelés beavatkozás

2. Vér nem tér vissza

   a. megállapitás

   b. megelőzés

   c. kezelés beavatkozás

3. Elzárodás

   a. megállapitás

   b. megelőzés

   c. kezelés/beavatkozás alvadás-ellenes eljárásokkal

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4. fertőzés

   a. megállapitás

   b. megelőzés

   c. kezelés/beavatkozás

5. katéter kijött a helyéből

   a. megállapitás

   b. megelőzés

   c. kezelés (beavatkozás a katéter eltávolitásával)

6. katéter vándorlás

   a. megállapitás

   b. megelőzés

   c. kezelés/beavatkozás

7. vénás trombózis

   a. megállapitás

   b. megelőzés

   c. kezelés/beavatkozás

F. Betegnevelés

1. a katéter leirása
2. katéter használat
3. katéter behelyezés
4. kijárati terület gondozása
5. katéter átöblitése és heparinizáció
6. cserélni injekció kupakot
7. lehetséges komplikációk

    a. elszakadás, eltépődés
    b. vér nem tér vissza
    c. elzárodás
    d. fertőzés
    e. kijön a helyéből a katéter
    f. katéter vándorlás
    g. trombózis

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GYERMEK-ONKOLOGÍAI SÜRGŐSSÉGI ESETEK

Pamela L. Cummings, R.N., B.S.N.

I. Typusok

A. Mechanikus

B. Anyagcserével kapcsolatos

II. Gyermek-onkológiai sürgősségi esetek

A. Mellkasi esetek

1. Vena cava superior syndrómája

2. A superior mediastinális syndroma

a. Etiológia
b. Pathofiziológia
c. Kiértékelés/Diagnózis
d. Kezelés

B. Pleurális és pericardiális izzadmányok (folyadék)

1. Definició (meghatározás)

2. Kiértékelés

3. Kezelés

C. Szivtamponád (cardiac tamponade)

1. Definició (meghatározás)

2. Etiológia és Pathogenezis

3. Kiertékelés/Diagnózis

4. Kezelés

D. Hasi sürgősségi esetek

1. Definició (meghatározás)

   a. Nyelőcső
   b. Gyomor
   c. Vékonybél
   d. Vakbélgyulladás
   e. Perirectális tályog
   f. Epehólyaggyulladas és epeút elzárodás
   g. Hemorhágiás pancreatitis

E. Húgy és nemiszervek sürgősségi esetei

1. Definició (meghatározás)

2. Pathofiziológia

3. Kiértékelés/Diagnózis

   a. Hemorrhagiás cystitis
   b. Vizelet-utak elzárodása

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F. Neurológiai sűrgősségi esetek

1. Definició (meghatározás)

a. Akut elváltozások az öntudatban (tudatzarvarok)

(1) Etiológia

(2) Pathofiziológia

(3) Kiértékelés/Diagnózis

(4) Kezelés

b. Cerebrovasculáris balesetek (gutaütés)

(1) Etiológia

(2) Pathofiziológia

(3) Kiértékelés/Diagnózis

(4) Kezelés

c. Epilepsziás rohamok

(1) Etiológia

(2) Pathofiziológia

(3) Kiértékelés/Diagnózis

(4) Kezelés

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d. Gerincvelő összenyomatása

(1) Etiológia

(2) Pathofiziológia

(3) Kiértékelés/Diagnózis

(4) Kezelés

G. Hyperleukocytozis

(1) Etiológia

(2) Pathofiziológia

(3) Kiértékelés/Diagnózis

(4) Kezelés

H. Anyagcserével kapcsolatos sürgősségi esetek

1. Tumor lizis (lysis) syndromája

(a) Etiológia

(b) Pathofiziológia

(c) Kiértékelés/Diagnózis

(d) Kezelés

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2. Hypercalcemia

   (a) Etiológia

   (b) Pathofiziológia

   (c) Kiértékelés/Diagnózis

   (d) Kezelés

3. Az inappropriate (nem megfelelő, vagy jogosult vagy megindolkolt) antidiuretikus hormontermelés syndromaja (SIADH)

   (a) Etiológia

   (b) Pathofiziológia

   (c) Kiértékelés/Diagnózis

   (d) Kezelés

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SUGÁRKEZELÉS

Pamela L. Cummings, R.N., B.S.N.

Besugárzást gyakran használnak gyermekkori rosszindulatu daganatok kezelésében, legtöbbször kemoterápiával és sebészi eljárásokkal egybekötve. Használható gyógyitási céllal, és gyakran tüneti kezelésre adják, enyhiteni a tüneteket azáltal hogy a daganat nagyságát csökkentik vele.

Ujabbkori haladás sugárkezelésben optimizálja a gyógyhatást és minimumra szoritja a nem-kivánatos mellékhatások nagy részét.

I. Cytotoxikus hatás.

A. Ionizáló sugárzás cytotoxikus legalább 3 külömböző úton.

1. Megsérti a pyrimidin bázisokat: cytosint, thymint és uracilt melyek szükségesek a nucleinsavak szintetizálásához.

2. Töréseket okoz DNA és RNA molekuláiban az egyszerü láncokban

3. Dupla láncokban is töréseket okoz ezekben a molekulákban.

A hatás mely létrejön azáltal hogy a sejt anyagcseréje és reproduktiv funkciója megsérül, lehet szubletális és letális.

Letális kár - azt jelenti, hogy a sejt elpusztul

Szubletális kár: a sejtek megsérülnek, de később magukhoz térhetnek és a kárt kijavithatják.

Az akut mellékhatások nagy része a letális hatások következménye ha a szövetek sugárérzékenyek, mint pl. csontvelő, gyomorbéltraktus és haj ill. szőrtüszők.

Késői mellékhatások lehetnek sejthalál következményei, mint pl. infertilitás, vagy a szubletális károsodás következményei, mint pl. időelőtti (gyorsított) öregedés, rövidebb élettartam.

Mellékhatások

Akut reakciók-függnek attól milyen terület lett besugározva, mennyi volt a totális adag, a gyermek kora (minél fiatalabb a gyermek, annál sugárérzékenyebbek a szervei), a daganat lokalizációja.

Teljes-test-besugárzás alkalmazása hozza maga után a legsúlyosabb reakciókat.

Összefoglalása az akut és késői hatásoknak radioterápia után.

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FÁJDALOM KIÉRTÉKELÉSE ÉS KEZELÉSE

Pamela L. Cummings, R.N., B.S.N.

I. Fájdalom kiértékelése.

A. Ha ismerjük hogy reagálnak a gyermekek fájdalomra, ez értékes adatokat nyujt a kiértékeléshez.

B. Alapvető feltevések fájdalom érzése és kifejezését illetően igen fontosak:

1. Fájdalom szubjektiv, személyes és nem lehet közvetlenül kommunikálni
2. Fájdalom össze van szőve olyan érzelmekkel mint félelem, aggódás, harag, magányosság, depresszió, és ezek az érzelmek fokozhatják a fájdalom érzését és kifejezését.
3. A fájdalom kifejezése változik a korral
4. Nem szavakkal kifejezett kommunikácio, különösen változás a viselkedésben megelőzi a a fájdalom szavakkal való kifejezését.

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Két kritérium minden-korbeli gyermekek monitorozására:

* fiziológiai reakció: szivverés, vérnyomás, pulzus
* viselkedésbeli reakció: figyeljük meg a sírás jellegét és időtartamát, szemmozgásokat, testmozgásokat, mennyi ideig tart stimulusokra reagálni.

C. Még nem beszélő gyermekek - csecsemők

1. Kifejezik a fájdalmat a következő viselkedésekkel

   a. Megfeszült testtartás

   b. ingerlékenység

   c. nem lehet vigasztalni a szokásos módszerekkel

   d. fejforgatás

   e. végtagok behajtása

   f. egy testrész dörzsölése vagy huzogatása

   g. letargia

   h. túlreagálás szokásos stimulusokra (ingerekre)

Reagálás fajdalom es rendszerint fizikai ellenállás

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D. Óvódások:

1. Főleg viselkedéssel fejezik ki a fájdalmat, de már szóban is megjelölik a fájdalom helyét.

2. Pszichoszomatikus fájdalom és a gyermek kulturájához tartozó kifejezések megnyilvánulnak, valamint kezdődik kifejlődni a képesség hogy a fájdalom kifejezését már kontrollálja.

3. Már lehet a gyermeket megkérni hogy egy skálán, pl. 1-9ig irja le a fájdalom súlyosságát.

E. Idősebb gyermekek.

1. Pontosabban leirják a fájdalmat, de már tudják eltitkolni vagy eltúlozni a fájdalmat személyes nyereség céljából. (Gondolom, ha el akarnak menni moziba vagy egy futballmeccsre JJK) De finomabb viselkedési tünetek, mint pl. elkínzott arckifejezés, merev tartása egy testrésznek, vagy szokatlan csendesség, szótlanság jelzik hogy fájdalom van jelen.

2. Skálán tudják kifejezni a fájdalom súlyosságát.

II. Fájdalomcsillapító gyógyszerek.

A. Nonsteroidal anti-inflammatory drugs (NSAIDS)

1.Acetaminophen - 10-15mg/kg PO Q 4h PO: szájon at Q: szor (X)

2.Aspirin (ASA) - 10-15mg/kg PO Q 4h

3.Ibuprofen (100mg/5ml) 3-8 mg/kg PO Q 4-8h

> 6 months

B. <u>Opioids</u>

cardiovascularis monitor inányelvek szerint adva

1.Morphine

a.0.05 - 0.1 mg/kg N Q 2-4h M: intramusculárisan SC subcután

b.0.02 -0.05mg/kg/h cont.IV

c.0.1 - 0.15mg/kg/M/SC Q 3-4h

d.0.1 - 0.2 mg/kg PO Q 4-6h

2.Meperidine (Demerol)

a.0.8 - 1 mg/kg N Q 2h

b.0.8 - 1 mg/kg 1M/SC Q 3-4h

3.Codeine

a.0.5 - 1.2 mg/kg PO Q 4h

4.Oxycodone (Percodan)

5.Methadone: 0.1 -0.2 mg/kg PO/IV q6-12h.

6.Levorphanol tartrate (Levo-Dromoran):

7.Hydromorphone (Dilaudid): 0.015-0.03 mg/kg IV/IM/SC q 3-4h

C. Nyugtatás gyermekgyógyászatban.

1.Nyugtatószerek ellenjavallatai:

a.teli gyomor. (szilárd ételek 8 óra, folyadékok 4-6 óra a ürülnek.)

b.légzési nehézségek

c.megzavart öntudat

Nyugtatókat az intézeti protocol irányelvei szerint kell adni.

2.Benzodiazepinek

a.javallatok: nyugtatás, aggódás-csökkentés, emlékezetvesztés. Kisebb adagokat kell adni, ha a beteg ópiátokat is kap szimultán.

b.Diazepam (Valium)

(1)0.2 -0.5mg/kg/dose PO

(2)0.05 - 0.2 mg/kg/dose IV

(3)(intramuscularisan hatástalan, nagyon fájdalmas)

c.Lorazepam (Ativan) - 0.05 mg/kg/dose IM/IV

d.Midazolam (Versed) - max dose 2/mg

0.035 - 0.2 mg/kg/dose IM/IV

0.5 mg/kg PO, 0.5 - 0.1 mg/kg PR

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3.Barbituratok - nyujstatásl és elalvánt okozuah

Pentobarbital (Nembutal) 2-4 mg/kg/a day PO, PR, IM

max a day 120 mg

4.Narcotic: l. Opioids section II - B okor: szedálást és

analgesiát

(javallatok: nyugtatás fajdalomcsillapitás)

5.Vegyes orvosságok:

a.chlorpromazine (thyroxine) 0.5 - 1.0mg/kg/a day 1M,

IV max. a day 50 mg

b.chloral hydrate - 25 - 100 mg/kg/a day PO, PR,

max a day 2gm

c.hydroxyzine (vistaril) - 0.5 - 1mg/kg/a day 1M

d.promethazine (phenergan) 0.025 - 0.1 mg/kg/a day

1M/IV

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6.(Gyogyszer kombináciok)

a.PO

(1)meperidine 1.5 mg/kg PO

(2)diazepam 0.2 mg/kg PO

(3)atropine 0.02 mg/kg PO

b.PO

(1)meperidine (demerol) 1.5 mg/kg PO

(2)thorazine (chlorpromazine)

2.5-6 mg/kg/24h ÷ Q 4-6h

(3)benadryl (diphenhydramine)

5mg/kg 24h ÷ Q 6h

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c.DPT Cocktail: max a day: 300 mg/24h

(lehet ugyanabban a fecskendőben keverni)

d.IM

(1)meperidine (demerol) 2mg/kg 1M

(2)promethazine (phenergan) 1mg/kg 1M

(3)chlorpromazine (thorazine) 1mg/kg 1M

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CARDIO-PULMONALIS (SZÍV-TÜDŐ) KIÉRTÉKELÉS

I. Személyzet.

A. Egy praktizáló aki végrehajtja az eljárást, amihez nyugtatás is szükséges.

B. Egy asszisztens aki ki van képezve felélesztésre és aki tud adni szivmegálláshoz használatos gyógyszereket és aki ismeri a rendelkezésre álló sürgősségi esetekhez való felszerelést.

C. Egy asszisztens aki stabilizálni és monitorozni tudja a beteget az eljárás közben.

II. Kiértékelés.

A. Eljárás közben.

1. monitorozni vitális jeleket, beleértve vérnyomást, oxigén telitettséget (szaturácio) pulzus oximeter segitségével, EKG, ha szükségesnek látszik és fizikai vizsgálat.

B. Az eljárás (procedura) után

1. monitorozni, mint fent, biztositani hogy légutak és keringés stabilak, beteg magánál van, tudatos és tud beszélni, beteg tud segitség nélkül ülni és járni.

III. Intravénás felszerelés elérhető legyen.

A. Legyenek katéterek külömböző méretben, folyadék infuziós felszerelés és intravénás folyadékok (Ringer lactate, dextrose 5% vizben, konyhasóval.)

Stabilis intravénas bekötés ajánlatos ha a beteg intravénás valiumot, versidet és Demerolt kap.

IV. Sürgősségi kocsi.

Biztositani, hogy a sürgősségi tólható asztalkocsin teljes felszerelés legyen leszivásra, oxigén, oxigén juttató szisztéma, és légutak kezelésére felszerelés (szájbeli légút biztositása, maszkok, laryngoszkópok, pengék, endotrachealis csövek, stylus).

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V. Gyógyszerek.

Legyen epinephrin, bikarbonát, atropin, lidocain, bretyllium, glucose, naloxone és physostigmin elérhető.

Reference: American Academy of Pediatrics Committee on Drugs. 1985: 76:317

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Hogy lehet rosszindulatu dagnatokkal szembenézni?

(Edna LaVonne Ridder R.N., M.A.)

I. Malignitásnak ("ráknak") hatalmas személyes és kulturális jelentősége van. A rákos beteg sokszor átinterpretálja mult életét a rákos tapasztalat világánál. (Ez vonatkozik szülőre is aki visszaemlékezik gyerekkori rákban szenvedő gyermeke életére)

A. A személyiség, sztressz és életstilus befolyása a malignitások okozatára

B. Kulturális jelentősége a ráknak

1. Halál és szenvedés mint tabu témák
2. Felkelti az anyagi katasztrófa érzését
3. Magával hoz terror érzést és az elárultatás érzését
4. Nem megfelelő társalgási téma

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II. Remélni szembeszállást jelent (Hoping is coping)

A. A személyes mult történet szerepe

B. A szituáció szerepe

C. Prediagnosztikus fázis

D. Diagnosztikus fázis

E. Kezelési fázis

F. Javulás fázisa

G. Visszaesés

H. Halál és meghalás

1. "Egészséges meghalás" mozgalom.

2. Halál értelmetlen

3. Módozatok a megértésre

COPING WITH CANCER

Benner, P. and Wrubel, J. (1989) The Primary of Caring: Stress and coping in Health and Illness. Menlo Park, California: Addison - Wesley Publishing Company.

Ellis, J. A. (1991) Coping with adolescent cancer: It's a matter of adaptation, Journal of Pediatric Oncology Nursing. 8(1) 10-17.

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Daganat kezelés késõi hatásai gyermekekben és serdülõ korban

Pamela L. Cummings, R.N., B.S.N.

I. A probléma dimenziói

A. Hosszútávu tulélés gyakorisága

B. A gyógykezelés költségeivel kapcsolatos problémák

C. A késõi hatások psychosociális befolyása a gyermekkori rákos betegség túlélõjére és családjára

II. Tényezõk melyek befolyásolják a túlelési arányszámokat gyermekkori rosszindulatu daganatokban

A. Faj

B. A daganat tipusa

C. A túlélés arányszáma összehasonlitva a gyermekkori malignitás gyakoriságával a diagnózis idején

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III. Késõi hatások a test külömbözõ szisztémáira

A. Központi idegrendszer

1. Késõi hatások:

2. Okok:

3. Kezelés:

B. Perifériás idegrendszer

1. Késõi hatások:

2. Okok:

3. Kezelés:

C. Látás/Hallás

1. Késõi hatások:

2. Okok:

3. Kezelés:

D. Fogak/Nyálmirigyek

1. Késõi hatások:

2. Okok:

3. Kezelés:

E. Keringési szervek

1. Késõi hatások:

2. Okok:

3. Kezelés:

F. Légzõszervek

1. Késõi hatások:

2. Okok:

3. Kezelés:

G. Izomrendszer/Csontrendszer

1. Késõi hatások:

2. Okok:

3. Kezelés:

H. Gyomorbéltraktus

1. Késõi hatások:

2. Okok:

3. Kezelés:

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I. Kiválasztási szervek (vesék/hugylevezető rendszer)

1. Késői hatások:

2. Okok:

3. Kezelés:

J. Belső elválasztási szervek, ivarszervek működése és szaporodás (reprodukálás)

1. Petefészek

a. Késői hatások:

b. Okok:

c. Kezelés:

2. Herék

a. Késői hatások:

b. Okok:

c. Kezelés:

3. Pajzsmirigy

   a. Késõi hatások:

   b. Okok:

   c. Kezelés:

4. Hypothathalamus/hypophysis tengely

   a. Késõi hatások:

   b. Okok:

   c. Kezelés:

K. Onkogenezis

I. Második rosszindulatu daganat

a. Második malignitást 5-17%-ra becsülik 20 évvel az eredeti diagnózis után

b. 20 szor olyan gyakori mint az általános lakosságban

c. kezeléssel kapcsolatos faktorok (tényezők)

d. beteggel kapcsolatos tényezők

L. Psychosociális komplikációk

1. Betegség és életbiztositás

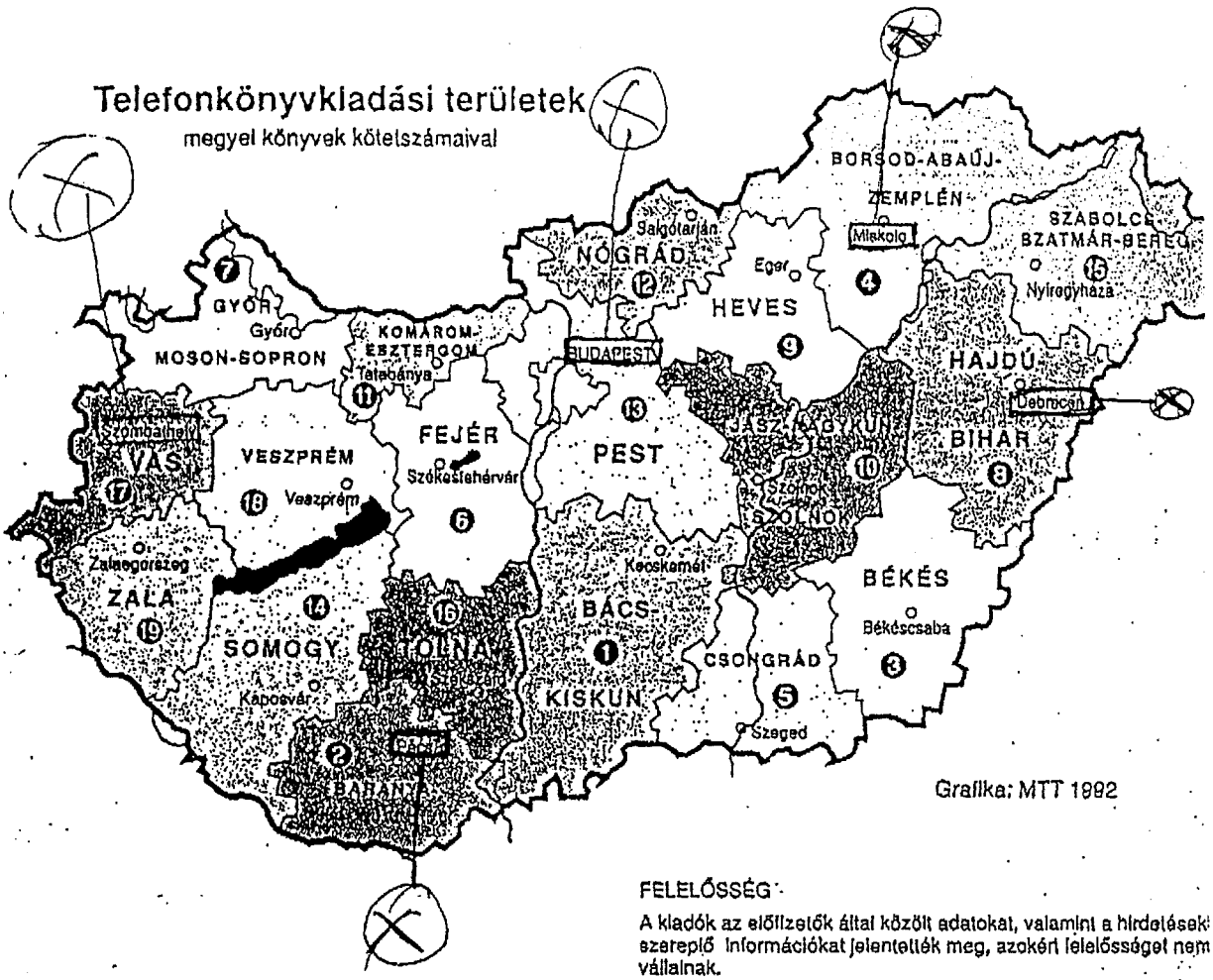
2. Házasság és válás

3. Alkalmaztatás

4. Benyomás sajátmagárol/ Önbecsülés/ Testképzet

5. Szociális következmények

6. Életstilus



FELELŐSSÉG

A kiadók az előfizetők által közölt adatokat, valamint a hirdetések szereplő információkat jelentették meg, azokért felelősséget nem vállalnak.

<u>Hospitals with Pediatric Components</u>

•Bethesda Children's Hospital
Budapest
•Madarász Children's Hospital
Budapest
•National Institute of Neurosurgery
Budapest
•St. László Hospital, Pediatric Dept.
Budapest
•1st Department of Pediatrics of the Semmelweis University Medical School
Budapest
•2nd Department of Pediatrics of the Semmelweis University Medical School
Budapest
•Heim Pál Children's Hospital
Budapest
•Medical University of Debrecen, Pediatric Dept.
Debrecen
•Medical University of Pécs, Pediatric Dept.
Pécs
•Center for Pediatric Health Care
Miskolc
•Hospital of the City Council, Pediatric Dept.
Szombathely

POOH PROJECT SUMMARY REPORT:
Nursing Symposium and Workshop
(Held at 2nd Pediatric Unit of Semmelweiss Medical School)
Budapest, Hungary

I. K.U.M.C. Participants:

E. Lavonne Ridder, ARNP, MA/MS, CNS Nurse Clinician	4/22 - 4/30/94
Pamela L. Cummings, RN, BSN Nurse Clinician	4/30 - 5/7/94
Tribhawan S. Vats, MD Chief of Pediatric Hematology/Oncology	4/27 - 5/4/94

II. Symposium Goal and Format:

Two nurse clinicians, E. Lavonne Ridder, Pamela L. Cummings, and physician, Tribhawan Vats, participated in the nursing workshop organized for hungarian nurses from Budapest and other centers in Hungary who were involved in the care of children with cancer. The workshop format was designed by oncologists and nurse clinicians from Semmelweiss in collaboration with Dr. Vats and his staff at The University of Kansas Medical Center (K.U.M.C.). The goal of this symposium was to share information gained by hungarian nurses who had obtained training at K.U.M.C. with nurses in other parts of Hungary. This symposium also provided a venue for K.U.M.C. staff to evaluate the training program which was designed for these Hungarian nurses.

During the workshop, didactic lectures were conducted by faculty and nurses from Semmelweiss and Dr. Vats and nurse clinicians from K.U.M.C. Didactic lectures were followed by open discussion among the participants and the faculty.

In addition, tours were made with the participants to look at inpatient unit and outpatient clinics, treatment areas of the 2nd Pediatric Department, and organized rounds were attended by all participants to demonstrate practical aspects of the training program.

III. Workshop Agenda:

Following is a listing of workshop presentations and presenters:

Day 1 The Role of the Nurse Clinician in the United States.

The Role of the Hungarian Nurse in the Past and Current.

Goals of Nursing in Hungary
- presented by Andrea Zifar

Nutrition of the Pediatric Oncology Patient
- T. S. Vats
- Lavonne Ridder
- Pamela Cummings

Fever and Neutropenia of the Pediatric Oncology Patient
- T. S. Vats
- Lavonne Ridder
- Pamela Cummings

Day 2

Central Venous Access Devices & Pain Control
- Judith Aranyosi
- Dr. Csaba Szentirmay

Intubation of the Pediatric Patient
- Judith Aranyosi

Sharing of Individual Nursing Experiences
- Six nurses from various institutions

Bone Marrow Transplantation
- Dr. Dezso Schuler
- Dr. Gergelly Krivan

Day 3

Psychologic Aspects of Pediatric Oncology Patients
- Csilla Zsambor, Psychologist

Pediatric Chemotherapy Administration
- Dr. Joseph Borsi

Day 4

Pediatric Oncologic Emergencies
- Judith Aranyosi

Experiences of Andrea Zafir in Kansas
- Andrea Zafir

Problems of Hungarian Nurses
- Six nurses from various institutions

Day 5

Alternative forms of Treatment of Pediatric Oncology Patient
- Tribhawan Vats, M.D.

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IV In Summary:

The entire course was repeated in two sessions.

Attendees were very enthusiastic and fully participated in open discussions.

The total number of nurses attending the first session was 8 and 7 nurses attended the second session.

Certificates of completion were awarded to all the nurses attending the workshop.

TSV/cf

Feb. 95

Pediatric Oncology Outreach to Hungary(POOH)
Nursing Section, Budapest, Hungary

Nurses representative of every hospital in Hungary, with a pediatric component, were present for the second of a series of nursing training sessions. The workshops are held with the intent to increase nursing knowledge of pediatric oncology nursing care and to improve nursing follow up of the patients after they leave the primary pediatric oncology center. Fourteen nurses from various institutions; two nurses from Semmelwies II, who coordinated the workshop and assisted with lecturing; and I attended the session which was from February 13 thru February 17, 1995.

Prior to the session a planning committee felt that the development of criteria to assist the nurses in evaluating their nursing care should be taught. Nursing standards, especially process standards which include nursing protocols, was presented. After the presentation, protocols were to be established by the nurses and were to define actions for effective management of problems in the care of pediatric oncology patients. Also these protocols were to assist the nurses in assuring quality and continuity of care of pediatric oncology patients. An example of a nursing care protocol for neutropenia was presented and translated with the nursing group present. Later, the nurses stated that the translation of the protocol in front of them greatly assisted them in their learning about protocols. Establishment of a protocol for each institution was accomplished by the attendees as a part of their certification process.

Other topics presented include the following:

- Enteral and parenteral nutrition
- Precautions in preparation of and administration of chemotherapeutic agents
- Radiation therapy
- Sepsis
- Home nursing care
- Hospice
- Ethical issues related to alternative therapies

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Antiemetic treatment
Communication issues
Rehabilitation in relation to care of the amputee
Pain
New chemotherapeutic agents

The nurses were actively involved with all discussions and enthusiastically verbalized concerns regarding the topics presented. Of special concern was that of alternative therapy which concerned nurses because proven care was not always received by the pediatric oncology patient.

The participant evaluations of the workshop showed much interest in the topics of new chemotherapeutic agents and in nursing standards. The nurses plan to meet during the upcoming POOH Symposium in May, 1995 and perhaps further discuss some of the topics presented at this meeting. Another exciting event to take place is that of a new Hungarian Pediatric Oncology Nursing Organization with the primary purpose of improvement of pediatric oncology nursing through continued education and networking.

Another POOH training session is planned for October in which the nurses plan to present topics to each other and continue with the formulation of nursing standards. It is very gratifying to be the part of a project such as this in which the participants are so motivated. Their great desire for the continued education and improvement of nursing care is indeed satisfying. The nurses taking part in the project have changed from being very dependent upon others to make their decisions to increasingly independent, collaborative health care providers. Thank you for allowing me to be a part of this great project.

Lavonne Ridder, ARNP, MA/MS, CNS

Pediatric Oncology Outreach to Hungary (POOH)
Nursing Section, Budapest, Hungary
September 25-29, 1995

The third of a series of nursing training sessions was held for nurses of every hospital with a nursing component in Budapest, Hungary at Semmelweiss University Medical School. The workshops are held with the intent to increase nursing knowledge of pediatric oncology nursing care and to improve nursing follow up of the patients after they leave the primary pediatric oncology center. Twelve nurses from various institutions; two nurses from Semmelweis II, who coordinated the workshop; and I attended the session which was from September 25 thru September 29, 1995.

It was decided by the planning committe and as a result of the second training session that information was needed about documentation, quality assurance, and standards. Also, the nurses were having difficulty in using nursing diagnoses, a way of assessing for and administering supportive care. The director of the local nursing school lectured on nursing standards and expressed the importance of documentation. The following day I lectured about ways documentation could be done in a timely fashion and the basics of quality assurance.

Other topics presented and discussed were very timely and included the following:

- Use of Erythropoietin in Pediatric Oncology
- Pain Relief in Pediatric Oncology
- Role of Leukocyte Filters in Supportive Therapy of Patients with Cancer
- Nephrotoxicity of Chemotherapy Agents
- Necessary Testing Prior to Bone Marrow Transplant
- Nutrition Needed for Treatment of Children with Malignant Diseases
- Epidemiology of Malignant Diseases
- The Parent Role During Treatment of the Child with Malignant Disease

The Importance of a Parent Support Group
Experiences of Home Nursing Care

A major development occurred during the training session. The Association of the Hungarian Pediatric Oncology Nurses was founded. Nurses not currently attending this educational session came especially for the founding meeting. The primary purpose of the organization is to improve nursing care given to the pediatric cancer patient. Professor D. Schuler actively supported the organization founding as did supervisory nursing persons in Hungary. I was made an honorary member.

More written information on nursing standards, nursing diagnosis, documentation, and quality assurance are to be mailed to Budapest. Informational support for the newly found organization will also be given as needed.

Plans are currently being made to present a poster of the nursing component of the POOH project at the Academic International Nursing Congress to be held September 16-18, 1996 in Kansas City, Missouri.

A camp for patients with cancer which integrates them with normal children is in the forming stages. A visit was made to the campground by Dr. Vats, Dr. Schuler, and myself. Information about fund raising for the camp was shared with the coordinators.

Lavonne Ridder, ARNP, CNS

Pediatric Oncology Outreach to Hungary (POOH)
Nursing Section, Budapest, Hungary
March 25-30, 1996

The fourth of a series of nursing training sessions was held for nurses of all the hospitals which work with children who have cancer. The meeting again took place at Semmelweiss University Medical School in Budapest, Hungary. The workshop was held with the intent of adding to the knowledge base of the nurses, planning for future meetings when the current USAID funding is no longer available, and sharing of changes which have been made. Fourteen nurses from various institutions; two nurses from Semmelweis II, who coordinated the workwhop; and I attended the session which was from March 25 thru March 30, 1996.

The nurses selected all the topics to be presented except for mine, which they allowed me to choose after looking at the tentative schedule they had chosen. I spoke about nonpharmaceutical methods of pain management. Presenters included nurses, a government worker, director of a nurses training center, a pharmacist and physicians. Other topics chosen include the following:

The role of growth factors in the treatment of children with malignant disease

Rational antibiotic therapy and prophylactic antibiotic treatment

Disturbances of acid-base balance in oncology patients

Role of energy rich nutrition in oncology

Side effects of chemotherapy and rescue possiblities

Brain tumors and treatment

Roles and ways of preparing chemotherapy agents

Surgery techniques for osteocoma and Ewing's sarcoma

Nursing documentation

Hematologic disturbances in malignancies

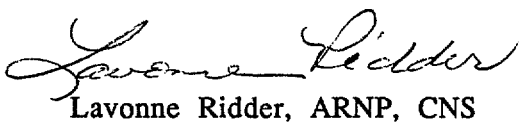
Problems of health insurance in pediatric oncology

Much discussion centered on documentation and lack of adequate nursing staff; problems with the new government third party payment system; and problems with the nurses preparing chemotherapy drugs.

On the last day, a meeting of the Hungarian Pediatric Oncology Nurses met. the Legal issues including signing of a charter was completed during the meeting.

Other recent developments which have occured as a result of the POOH project are the nation wide registration of all nurses in Hungary which is scheduled to begin June 1 and a program to train advanced level nurses as practitioners in the area of pediatric oncology which is planned to start in about six(6) months.

Two nurses from Semmelweis will come to The University of Kansas to assist in presenting a panel discussion about the POOH project at the Second Nursing Academic International Congress, International Collaboration in Nursing: Working Together to Enhance Health Care which will take place September 16-18, 1996. Developments which have taken place as a result of POOH are to be shared at this meeting.



Lavonne Ridder, ARNP, CNS
Pediatric Hematology/Oncology
University of Kansas Medical Center

Appendix H.

HUNGARIAN PHYSICIANS AND MEDICAL SCIENTISTS TRAINED AT KUMC:

Name	Discipline
Valeria Klujber, M.D.	Immunology, Flow Cytometric Aided Diagnostics
Thomas Feréncz, M.D.	Pediatric Hematology/Oncology, Treatment Protocols
Joseph Borsi, M.D., Ph.D., D.Sc.	Pediatric Hematology/Oncology, Clinical Pharmacology
Csilla Csaki, M.D.	Pediatric Hematology/Oncology, Transfusion Requirements of Children with Cancer
Hedvig Bodánszky, M.D., Ph.D.	Pediatric Gastroenterology, Nutritional Assessments in Children with Cancer
Belá Kocsis, M.D.	Radiation Oncology in Pediatrics
Enikö Apjok, M.D.	Data Management, POOH Pediatric Tumor Registry
Denés Zámaroczky, M.D.	Neurology, Pediatric Oncology Epidemiology
Felecia Slowik, M.D.	Neurological Pathology
Krisztina Paál, Ph.D.	Clinical Pharmacology, High Pressure Liquid Chromatography

Appendix I.

MEDICAL SYMPOSIA AND CONTINUING EDUCATION PROVIDED TO HUNGARIAN PARTICIPANTS BY THE POOH PROJECT:

1. Dr. Enikö Apjok, Data Manager at SDP, attended three annual meetings of the International Association of Cancer Registries in 1995, 95, and 96, in Canada, Brazil, and Scotland. She presented a poster for the POOH Pediatric Tumor Registry at each meeting.

2. Dr. Felecia Slowik, Neuropathologist at NINS, attended the XIIth International Congress on Neuropathology in Ottawa, Canada in 1994. She presented a case during the meeting entitled, "Intrasellar Neuronal Hamartomas Associated with Acromegaly"

Dr. Slowik also attended the Seventy-First Annual Meeting of the American Association of Neuropathologists, in San Antonio, Texas, USA, in 1995.

3. Dr. Béla Kocsis, Radiation Oncologist at the National Institute of Oncology, attended the 35th Annual .Meeting of the American Society for Therapeutic Radiology and Oncology in New Orleans, Louisiana, USA.

4. Dr. Joseph Borsi, Chief of Pediatric Oncology, SDP, attended the Sixth International Symposium on Pediatric Neuro-Oncology at the University of Texas, MD Anderson Cancer Center, Houston, Texas, USA, in 1994. Dr. Borsi presented a short lecture on the treatment of Pediatric Brain Tumors in Hungary, using POOH data.

5. Dr. Csilla Csaki, Pediatric Oncologist, SDP, attended the Sixth International Symposium on Pediatric Neuro-Oncology at the University of Texas, MD Anderson Cancer Center, Houston, Texas, USA, in 1994. Dr. Csaki presented a poster on the treatment of Pediatric Brain Tumors in Hungary, using POOH data.

6. Dr. Krisztina Paál, Pharmacologist, SDP, attended a continuing education training in the advanced use of High Pressure Liquid Chromatography in London, England in 1995.

7. Mrs. Judit Aranyosi, Pediatric Oncology Nurse Clinician, SDP, attended and presented a short lecture on Pediatric Oncology Nursing in Hungary at the USAID Annual Partnership in Health Care Meeting in Warsaw, Poland in 1993.

8. Mrs. Judit Aranyosi, Pediatric Oncology Nurse Clinician, SDP, and Ms Krisztina Deak, Pediatric Oncology Nurse Clinician, SDP, attended and presented a lecture at the Second Nursing Academic International Congress: International Collaboration in Nursing at the University of Kansas Medical Center, Kansas City, Kansas, USA, in 1996. Mrs. Aranyosi and Ms Deak presented a lecture on Pediatric Oncology Nursing in Hungary, and the POOH Project.

HODGKIN'S DISEASE

EARLY HD.

First line
Salvage therapy (XRT only)
Relapse HD
2nd relapse (ICE)

ADVANCED HD

Front line
Relapse HD (same as for early)
2nd relapse (ICE)

B-CELL ALL

CLASSIFICATION
SPECIAL STAIN (PAS,Sudan black,NSE,acid phosphatase)
IMMUNOPHENOTYPING
CYTOGENETICS
DNA-INDEX
SERUM-bank,SLIDE-bank

LARGE CELL NHL STG 111/1V

First line
Induction failure (ICE)
Recurrent NHL (BMT)

DIFFUSE STG 111/1V NHL

Induction (same as B-cell ALL)
Induction failure (ICE)
Recurrent NHL (BMT)

PRE - B ALL

CLASSIFICATION BM - ------→ SPECIAL STAINS (PAS, SUDAN BLACK NSE, ACID PHOSPHATASE)

------→ IMMUNOPHENOTYPING
------→ CYTOGENETICS
------→ DNA INDEX
------→ CELL BANK
------→ SERUM BANK
------→ SLIDE BANK

INFANTS (LESS THAN ONE YEAR OF AGE)

GOOD RISK ALL (SEE APPENDIX I FOR CLASSIFICATION OF RISK GROUP)

HIGH RISK ALL

INDUCTION FAILURE

ISOLATED CNS RELAPSE

1ST BM RELAPSE

MULTIPLE BM RELAPSE

INDUCTION FAILURE PRE B-ALL

INDUCTION PHASE

	WEEK 1	WEEK 2	WEEK 3	EVALUATE
MTX	↑	↑	↑	M_1 - go to continuation
6 MP	↑	↑	↑	Improved, give wks 4&5 (as week 1 without TIT)
TIT	↑	↑	↑	M_3 - off study
Leucovorin	↑	↑	↑	

MTX	200mg/M^2 IV push followed by 800 mg/M^2 IV over 24 hrs.
6-MP	200mg/M^2 over 20 minutes followed by 800 mg/M^2 over 8 hrs.
TIT	MTX/HDC/ARA-C age adjusted
Leucovorin	5mg/M^2 IV OR PO q 6 hrs. X 5, 24 hrs. after completion of MTX

INDUCTION FAILURE PRE B ALL

CONTINUATION PHASE (REPEAT 8 WEEK CYCLE X 16)

WEEK	1	2	3	4	5	6	7	8
HD ARA-C	↑							
TIT		↑					↑	
VP-16				↑				
Ifosfamide				↑				
MESNA				↑				
IDMTX							↑	
6 MP							↑	
Leucovorin							↑	
MTX IM								↑
6-MP PO								↑
G-CSF	↑	↑	↑	↑	↑	↑	↑	↑

G-CSF	24 hrs. post chemo 5mg/kg/day SQ
HD Ara-C	3 g/M^2 IV over 3 hrs. q 12 hrs. X 4 doses
VP-16	100mg/M^2 IV over 1 hr. x 3 days
Ifosfamide	2.8 g/M^2 IV over 1 hr. X 3 days
MESNA	400 mg/M^2 X 5/days x 3 days
IDMTX	200 mg/M^2 IV push then 800 mg/M^2 IV over 24 hrs.
6 MP	200 mg/M^2 IV over 20 min. then 800 mg/M^2 over 8 hrs.
MTX IM	2mg/M^2
6-MP PO	50 mg/M^2 X 7 days
TIT	MTX, HDC, ARA-C (age adjusted)
Leucovorin	5 mg/M^2 IV or PO q 6 hrs. X 5 24 hrs. after MTX

IFOS--1st relapse for Ependymomas
Brainstem glimoa
Children <3 years

IDARUBICIN--2nd relapse for Ependymomas
Brainstem glimoa
Children <3 years

1st relapse for LG Astrocytomas
Optic Pathway
Supratentorial
HG Medulloblastoma

No remission--ABMT--all

Brain Stem Gliomas >3yr

SCHEMA OF TREATMENT

Week:	1	2	3	4	5	6
Conventional: 180 cGy/day to 5400 cGy	XXXXX	XXXXX	XXXXX	XXXXX	XXXXX	XXXXX
RT						
Hyperfx: 117 cGy BID to 7020 cGy	XXXXX XXXXX	XXXXX XXXXX	XXXXX XXXXX	XXXXX XXXXX	XXXXX XXXXX	XXXXX XXXXX
Chemo: Cisplatin 100 mg/M^2 continuous infusion* x 120 hrs.	----------		----------		----------	

* Cisplatin will begin prior to the first dose of RT on day 1 of each cisplatin course

APPENDIX III

RADIOTHERAPY TOXICITY CRITERIA

	0	1	2	3	4
Skin					
a) Acute	None	Erythema	Dry desquamation	Moist desquamation	Severe confluent & moist desquamation; slough
b) Chronic	None	Hyperpigmentation	Atrophy	Subcutaneous fibrosis	Ulceration; necrosis
Hematopoietic					
a) Hematocrit	≥36%	≥30%-<36%	≥24%-<30%	≥18%-<24%	<18%
b) WBC	≥4000	3000-3999	2000-2999	1000-1999	<1000
c) Platelets	≥100,000	75,000-99,999	50,000-74,999	25,000-49,999	<25,000
Alopecia	None	Minimal hair loss	Moderate, patchy loss	Complete-probably reversible	Essentially complete-irreversible
Pulmonary					
a) Acute	None	Increased cough, minimal dyspnea; suggestive x-ray findings without symptoms	Low grade fever, cough, moderate dyspnea, x-ray findings	Fever, severe cough, marked dyspnea on exertion	Hospitalization
b) Chronic	None	Linear streaks on x-ray	Mild opacification, some lung seen	Moderate opacification, some lung appreciate in pattern	Complete opacification-Nonfunctional segment
c) Physiological	None	Pulmonary function, any parameter <75% of Pre-Rx	Pulmonary symptoms, Rx needed; no ventilatory assistance	Pulmonary symptoms; Rx needed; occasional outpatient ventilatory assistance with oxygen IPPB.	Assisted ventilation needed frequently hospitalization needed for support & treatment
Cardiac					
a) Myocardial	None	EKG changes, sinus tachycardia <110 at rest	Arrhythmias except ventricular tachycardia with/without EKG changes	Mild congestive heart failure	Severe congestive heart failure Arrhythmia requiring pacemaker, ventricular tachycardia
b) Pericardial	None	Asymptomatic pericardial effusion (x-ray or ultrasound diagnosis)	Pericarditis or pericardial effusion with symptoms suggesting restricion-intervention not necessary	Pericarditis or pericardial effusion with tamponade requiring tap	Constrictive pericarditis or pericarditis with restrictive disease requiring surgical intervention
Hepatic	SGPT-normal SGOT-normal Bilirubin-normal Alkaline Phos-normal	1.1 - 2 x normal No ascites	2.1 - 5 x normal Transient ascites	5.1 - 10 x normal Persistent Ascites-Impending liver failure requiring peritoneal needle tap	10 x normal

APPENDIX III

RADIOTHERAPY TOXICITY CRITERIA

	0	1	2	3	4
Gastrointestinal					
a) Oral					
A. Acute	Normal	Faint erythema	Patchy mucositis, brisk erythema	Confluent fibrinous, mucositis, ulceration, pain	Mucosal necrosis; hemorrhage
B. Chronic		Mild telangectasia	Thin depigmented mucosa	Superficial ulceration	Nonhealing ulcer or fistula
b) Bowel					
A. Acute					
I. Small bowel	None	Mild-no treatment	Moderate-Rx relieves	Moderate-Rx does not relieve	Severe-requires parenteral medications and/or hospitalization
II. Colon	None	Semisolid stool; antispasmodic medication	Watery movements <4/day. No hydration responsive to antidiarrheals	Water movements >4/day. Unresponsive to antidiarrheals	Hemorrhagic diarrhea or needs hydration
III. Stomach	None	Slight nausea, no vomiting	Nausea, occasional vomiting	Nausea, vomiting 1-3/day	Severe nausea continuous vomiting
IV. Esophagus	None	Odynophagia, dysphagia, no treatment required	Odynophagia, dysphagia, antacids or viscous xylocaine needed	Odynophagia, dysphagia lasting longer than 14 days after rad. in spite of symptomatic treatment	Odynophagia, dysphagia, 10% loss of body weight, dehydration hospitalization required
B. Chronic		2-3 semisolid stools/day	Occasional crampy pain &/or mild tenesmus	Persistent abdominal cramps malabsorption, severe tenesmus	Bowel obstruction; fistulae, organ stricture or ulceration
Genitourinary					
a) Bladder	None	Dysuria-no treatment	Dysuria-requiring Rx &/or microscopic hematuria	Gross hematuria	Hematuria with drop in hgb. or 2 gm %.
b) Kidney	BUN ≤20 Creatinine ≤1.5	BUN 21-40 1.5-2.0	41-60 2.1-4.0	60-100 >4.0	Irreversible renal failure (complete shutdown)
	Creatinine Clear >95%	76-94%	51-75%	<50%	
CNS					
a) Acute	None	Mild anxiety, drowsiness or headache	Excessive anxiety or nervousness, somnolence; 1+ papilledema, mild pareas or sensory loss, moderate headache	Severe paresis; confusion; seizures; 2+ papilledema, severe headache	Suicidal behavior Coma
b) Chronic	None	Mild paresthesias, transitory-Lhermitte's, decreased deep tendon reflexes	Severe paresthesias, mild muscular weakness, tremor, absent deep tendon reflexes	Disabling sensory loss, severe peripheral nerve pain, severe muscular weakness, bladder dysfunction, bowel dysfunction	Paralysis; muscular-confining patient to bed or wheelchair; bowel & bladder-incontinence; coma
General Weight	Stable or gain	Loss <5% of initial weight	Loss 5.1-10% of initial weight	Loss 11-20% of initial weight	Loss >20% of initial weight

CNS Tumors < 3

S* U R G E R Y → RANDOMIZE

REGIMEN A (Control):

Wk:	1	5	9	12	13	17	21	24	25	29	33	36	37	41	45	48	49	53	57	60	61	65	69	73
	A	A2	B	E	A	A2	B	E	A	A2	B	E	A	A2	B	E	A	A2	B	E	A	A2	B	E → XRT†
				V				V				V				V				V				V
				A				A				A				A				A				A--CR → Follow
				L*				L*				L*				L*				L*				L--PD → (XRT†)

REGIMEN B (Test)

Wk:	1	4	7	10	12	13	16	19	22	24	25	28	31	34	36	37	40	43	46	48	49	52	55	58	60	61	64	67	70	74
	X	X	Y	X	E	X	Y	X	X	E	Y	X	X	Y	E	X	X	Y	X	E	X	Y	X	X	E	Y	X	X	Y	E → XRT†
					V					V					V					V					V					V
					A					A					A					A					A					A
					L*					L*					L*					L*					L*					L
																														CR → Follow
																														PD → (XRT†)

REGIMEN A:

Cycle A

Day 1: Vcr 0.065 mg/kg
Cyc 65 mg/kg
Mesna 13 mg/kg hrs 0, 3, 6, 9, 12

Days 8, 15, 22: Vcr 0.065 mg/kg

Cycle A2

Day 1: Vcr 0.065 mg/kg
Cyc 65 mg/kg
Mesna 13 mg/kg hrs 0, 3, 6, 9 12

Day 8: Vcr 0.065 mg/kg

Cycle B

Day 1: CDDP 4.0 mg/kg

Days 3 & 4: VP-16 6.5 mg/kg

REGIMEN B:

Cycle X

Day 1: Vcr 0.065 mg/kg
Cyc 65 mg/Kg
Mesna 13 mg/kg hrs 0, 3, 6, 9, 12

Day 2: Cyc 65 mg/kg
Mesna 13 mg/kg hrs 0, 3, 6, 9, 12

Days 8 & 15: Vcr 0.065 mg/kg
Days 3-15: G-CSF 10 µg/kg/dose, SQ or IV

Cycle Y

Day 1: CDDP 5.0 mg/kg

Days 3 & 4: VP-16 7.5 mg/kg

Days 5-14: G-CSF 10 µg/kg/dose SQ or IV

* PD → XRT
† XRT volume and dose to be determined by age and histology

CNS Tumors <3

RADIATION THERAPY DOSE GUIDELINES

	Disease	Age at Rx	CSI dose	Primary Boost/ Cone Down	Total Dose	CSI Met Boost
A:	Neuraxis negative:					
	Medulloblastoma, cerebellar anaplastic astrocytoma or glioblastoma multiforme; malignant germ cell tumor; pineoblastoma; ependymoblastoma; poorly-differentiated embryonal tumor; choroid plexus carcinoma, intracranial sarcoma	<18 mos	27 Gy in 18 fx	14.4 Gy in 8 fx + 7.2 Gy in 4 fx	41.4 Gy →48.6 Gy	
		18-30 mos	30 Gy in 20 fx	14.4 Gy in 8 fx + 7.2 Gy in 4 fx	44.4 Gy →51.6 Gy	
		>30 mos	34.5 Gy in 23 fx	12.6 Gy in 7 fx + 7.2 Gy in 4 fx	47.1 Gy →54.3 Gy	
B:	Neuraxis negative:					
	Ependymoma; supratentorial anaplastic astrocytoma or glioblastoma multiforme; brain stem glioma	<18 mos		40.5 Gy in 27 fx + 7.5 Gy in 5 fx	40.5 Gy →48.0 Gy	
		18-30 mos		43.2 Gy in 24 fx + 7.2 Gy in 4 fx	43.2 Gy →50.4 Gy	
		>30 mos		46.8 Gy in 26 fx + 7.2 Gy in 4 fx	46.8 Gy →55.2 Gy	
C:	Neuraxis involvement at dx or subsequently:					
	Tumor of any histology	<18 mos	30 Gy in 20 fx	10.8 Gy in 6 fx + 7.2 Gy in 4 fx	040.8 Gy →48.0 Gy	15 Gy in 10 f
		18-30 mos	33 Gy in 22 fx	10.8 Gy in 6 fx +7.2 Gy in 4 fx	43.8 Gy →51.0 Gy	10.5 Gy in 7 f
		>30 mos	39 Gy in 26 fx	9.0 Gy in 5 fx + 7.2 Gy in 4 fx	48.0 Gy →55.2 Gy	9.0 Gy in 6 f

Supratentorial >3yrs

	Week:	1				5				9				
	Day:	1	2	3	4	1	2	3	4	1	2	3	4	
RANDOMIZE →	**Treatment A**	DDP	→	→	→	DDP	→	→	→	DDP	→	→	→	----Off Study → POG #9136*
		||||	||||	||||		||||	||||	||||		||||	||||	||||		
→	**Treatment B**	VP	→	→	→	VP	→	→	→	VP	→	→	→	----Off Study → POG #9136*
		↑↑↑↑	↑↑↑↑	↑↑↑↑		↑↑↑↑	↑↑↑↑	↑↑↑↑		↑↑↑↑	↑↑↑↑	↑↑↑↑		

Treatment A:
DDP = Cisplatin 40 mg/M^2/24 hrs continuous infusion x 72 hrs
| = BCNU 10 mg/M^2 IV over 15 minutes q 6 hrs
Cisplatin infusion will be interrupted during administration of BCNU

Treatment B:
VP = VP-16 200 mg/M^2/24 hrs continuous infusion x 72 hrs
↑ = Cyclophosphamide 150 mg/M^2 IV over 30 minutes q 6 hrs
VP infusion will be interrupted during administration of cyclophosphamide

* After completion of therapy, patients will go off study and will register on POG #9136 for treatment with hyperfractionated irradiation. Patients who develop PD at any time will go off study and immediately register on POG #9136.

Supratentorial >3yrs

Schema of Treatment and Dose Escalation

Group A:

	Dose Level 1	Dose Level 2
Primary	= 55.20 Gy in 46 fx, b.i.d.	55.20 Gy in 46 fx, b.i.d.
Primary Boost	= 14.40 Gy in 12 fx, b.i.d.	→ 21.60 Gy in 18 fx, b.i.d.
Total Dose	= 69.60 Gy in 58 fx, b.i.d.	→ 76.80 Gy in 64 fx, b.i.d.

End of Therapy ←--4 wks--→

Group B:

	Dose Level 1†	Dose Level 2
Primary	= 43.20 Gy in 36 fx, b.i.d.	43.20 Gy in 36 fx, b.i.d.
Primary Boost	= 24.00 Gy in 20 fx, b.i.d.	→ 31.20 Gy in 26 fx, b.i.d.
Total Dose	= 66.0 Gy in 60 fx, b.i.d.	→ 74.40 Gy in 62 fx, b.i.d.

† Pts. with +CSF: Dose to primary volume = 50.40 Gy in 42 fx, b.i.d.
Dose to primary boost = 16,80 Gy in 14 fx, b.i.d.
Total dose = 67.20 Gy in 56 fx, b.i.d.

Pts. with +MRI/myelogram: Total dose to spinal boost field = 57.60 Gy in 48 fx, b.i.d

Group A: Patients with localized glial tumors
Group B: Patients with PDTS or with glial tumors and neuraxis spread.

* Patients with unacceptable toxicity or PD on #9135 will be off study and will register immediately on #9136

Ependymomas

FIELD MARGIN SUMMARY

RT Dose (GY)	Intracranial Target Volume	Inferior Cervical Margin
No Tumor below Foramen Magnum:		
0 - 46.8	Posterior fossa	C3-C4 interspace
46.8 - 58.8	Posterior fossa	C1-C2 interspace
58.8 - 69.6	Pre-op tumor + 2 cm	C1-C2 interspace
Tumor below Foramen Magnum Pre-operatively (no postoperative spinal tumor):		
0 - 46.8	Posterior fossa	2 vertebral bodies below pre-op tumor margin
46.8 - 58.8	Posterior fossa	1 vertebral body below pre-op tumor margin
58.8 - 69.6	Pre-op tumor + 2 cm	C1-C2 interspace
Tumor Below Foramen Magnum (with residual postoperative spinal tumor*):		
0 - 46.8	Posterior fossa	2 vertebral bodies below residual tumor margin
46.8 - 58.8	Posterior fossa	1 vertebral body below residual tumor margin
58.8 - 69.6	Pre-op tumor + 2 cm	1 cm. below residual tumor margin

*Residual tumor defined by operative report and post-operative neuroimaging

6.324 RT Dose Definition

6.3241 Absorbed dose will be described in Gray (Gy) to water.

6.3242 The prescription point is on the central axes of the opposing beams, midway between the two lateral entrance points of the largest fields, if more than one configuration is used.

6.33 Time-Dose Considerations

6.331 Treatment shall be given twice daily, with a minimum interval of 6 hours between the two fractions. The actual interval shall be recorded in the treatment records.

6.332 The total dose is approximately 33% greater than that considered a standard dose in daily fraction for this disease.

6.333 All fields should be treated twice each day, 5 days per week. There will be no planned rests. Any unplanned interruptions should be discussed with the Radiation Oncology Coordinator, Dr. Walter Curran, (215) 728-3692.

6.334 The total dose to the prescription point, the fraction size, and the overall treatment time shall be as follows:

Total XRT Dose to Pre-Op Tumor Volume + 2 cm	Fraction Size	# of Fractions	Overall Time
69.6 Gy	1.2 Gy	58	6 weeks

6.34 Dose Homogeneity and Off-Axis Reference Points

6.341 Uniformity Requirements

An attempt should be made to minimize the variation of radiation dose within the stated RT target volumes. The maximum variation in dose shall be no more than +/- 5% of the isocentric prescription point. If portions of the cervical spine are receiving >5% of the prescribed dose, an adjustment in the inferior field margin should be made at the appropriate total RT dose so that the specified total RT dose for that portion of the cervical spine is not exceeded.

6.342 In order to ensure dose homogeneity, the doses at the reference points, defined along the central axis of the opposed beams at the C1 and C3, should be calculated and recorded.

6.35 Treatment Technique

6.351 Treatment Fields

The posterior fossa/upper cervical spine should be treated by an arrangement of two opposing lateral fields.

6.352 Patient Position

Patients can be in either a supine or prone position for treatment. Immobilization devices such as head molds are encouraged. It is critical that patients be immobilized in the same position for each treatment. Anesthesia may be required.

6.353 Required Field Shaping

Customized lead alloy blocks should be used when necessary for defining the initial field margins as well as for the conedown portion of treatment after 46.8 and 58.8 Gy.

6.36 Dose Calculation

Isodose distributions and calculations should be obtained using a patient contour and anatomical information from an MRI and/or CT scan.

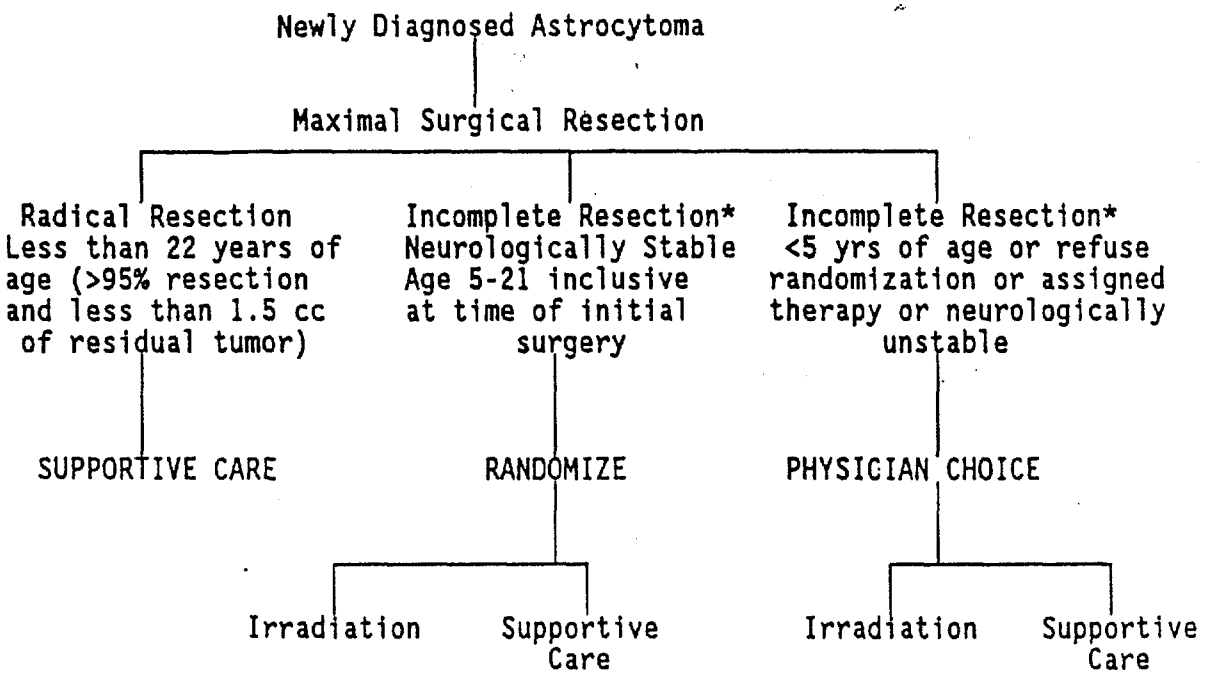
6.37 Quality Assurance Documentation

6.371 The following radiotherapy data shall be submitted within three days after the onset of treatment:

- Copies of CT or MRI scans showing the original complete extent of the lesions, and other relevant diagnostic materials used in determining the boost volume.

L.G. ASTROCYTOMA I.

3.5 Study Schema (see Sections 9.1-9.15 for surgical definitions)



* ≥1.5 cc residual tumor or ≤95% tumor resected.

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Low-Grade Astrocytoma II

10.0 RADIATION THERAPY GUIDELINES

Radiotherapy will be started as soon as the surgical wound has healed and the patient's condition permits. It must be started within 28 days following entry on study.

Much of the concern surrounding radiation of the brain in children is related to the observed long-term effects on intellectual development, behavior and endocrine function. The low-grade astrocytomas, however, appear to be circumscribed lesions without significant infiltration into the surrounding brain. That being the case, the current study will use strictly limited treatment volumes to minimize irradiation of normal tissue.

10.1 Treatment Specifications

The original tumor volume will be identified by preoperative CT or MRI. Where initially contrast enhancement of the tumor was present, treatment planning will be based on the preoperative scan. In the absence of tumor contrast enhancement, the original area of the abnormal MRI signal or hypodensity on CT will be accepted as the tumor volume. Areas interpreted as edema will not be included as tumor volume.

Tumor volume to be irradiated shall be the volume of enhancement on contrast CT or MRI plus a 2 cm margin.

Treatment technique will be planned to encompass the necessary treatment volume by whatever technique is necessary to minimize irradiation of normal brain, e.g., wedged pairs, multiple fields.

Treatment must be given on a linear accelerator of minimum SAD 80 cm.

10.11 Dose Reference Points

Parallel opposed equally weighted beams: midplane dose on central axis.

Other techniques: The treatment volume will be encompassed by the 95% isodose volume. Variations within the volume should not exceed ± 5%.

10.12 Dose

5400 cGy (spinal cord - 5040 cGy).

Daily fraction size: 180 cGy.
All fields to be treated daily (5 days per week).

10.13 Tissue Compensation

Compensators may be used as necessary.

10.14 Protection of Sensitive Structures

Whenever possible, an attempt should be made to ensure that the pituitary and the middle ear are excluded from the treatment volume.

10.15 Immobilization

Immobilization by cast is recommended.

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APPENDIX II
TREATMENT SCHEMA

High Dose Melphalan and Cyclophosphamide with Autologous Bone Marrow (ABM) Rescue for Recurrent/Progressive Malignant Brain Tumors in Children

Day (up to)	Preparation	Other Meds	Procedures	Labs
-12	Bone marrow harvest			
- 8	Cyclophosphamide (dose to be determined)	MESNA 360 mg/M^2 x 5 doses Allopurinol 150 mg/M^2	Hydration 2400-3000 cc/M^2/D	Lytes, Osmo
- 7	Cyclophosphamide (dose to be determined)	MESNA 360 mg/M^2 x 5 doses Allopurinol 150 mg/M^2	Hydration 2400-3000 cc/M^2/D	Lytes, Osmo
- 6	Cyclophosphamide (dose to be determined)	MESNA 360 mg/M^2 x 5 doses Allopurinol 150 mg/M^2	Hydration 2400-3000 cc/M^2/D	Lytes, Osmo
- 5	Cyclophosphamide (dose to be determined)	MESNA 360 mg/M^2 x 5 doses Allopurinol 150 mg/M^2	Hydration 2400-3000 cc/M^2/D	Lytes, Osmo
		Stop MESNA	Withhold intra-lipids, A.A. from TPN	
- 4	Melphalan 60 mg/M^2/D		Hydration 2400 cc/M^2/D	Lytes
- 3	Melphalan 60 mg/M^2/D			Lytes
- 2	Melphalan 60 mg/M^2/D	Begin Fluconazole		Lytes
- 1	Rest	Begin Fluconazole	IV IGG Resume TPN	
- 0	Bone marrow infusion			

Rev:03/08/91

Idarubicin

Relapse

WK:	0		3		6		9		12		15		
DAY:	1	5	1	5	1	5	1	5	1	5	1	5	...*
	I	↑	I	↑	EVAL				EVAL				EVAL

I = Idarubicin 18 mg/M^2 over 4 hours on day 1

↑ = G-CSF 5 μg/kg SQ daily, beginning on day 5 and continuing until count recovery (Sec 6.2)

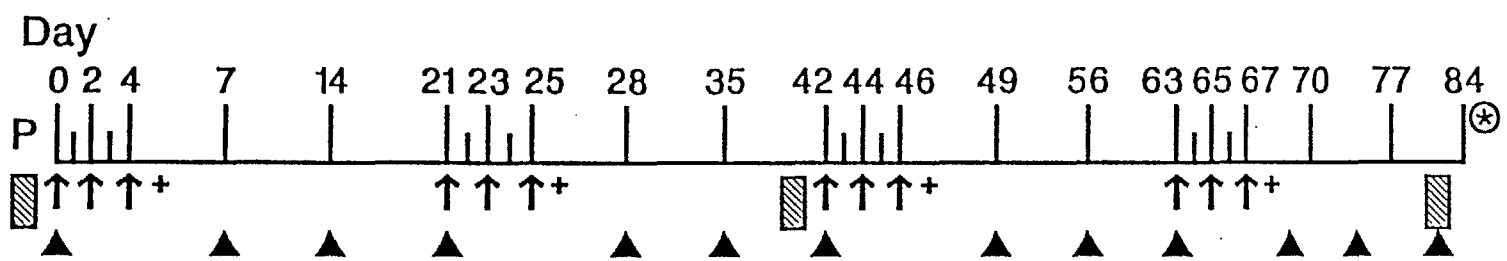
Evaluation after completion of every 2 cycles. Patients may continue on therapy as long as they continue to demonstrate at least stable disease, for a total of 6 cycles.

* Further therapy may be given at investigator's discretion, with attention to potential cardiac toxicity; imaging studies must be repeated after every 2 additional cycles. Patients will have a final evaluation after therapy.

QOD Ifosfamide

Appendix A. Treatment Schema

Schema



P Prestudy evaluation (see section 5.4)

↑ Ifosfamide. 3gm/m^2/day every other day x 3 doses

▨ MRI/CT and neurologic evaluation

▲ Weekly CBC

\+ See section 5.4 for required studies on therapy

⊛ Repeat cycles every 21 days if patient continues to demonstrate at least stable disease

High Stage Medulloblastoma >3 yrs old

Schema of Therapy

TRT 1: Pre-Irradiation Chemotherapy — Radiation Therapy — ←3 wks→ — Post-XRT Chemotherapy

Week:	1			4			7			10													
Days:	1	3	4	1	3	4	1	3	4	1													
	P			P			P																
		E	E		E	E		E	E														

RANDOMIZE

Posterior fossa + boost (6½ wks**)

Whole brain (4½-5 wks*)

Spine (4½-5 wks*)

Days:	20	24	28	32	36	40	44	48
	1	2						
	V		Repeat q 4 wks x 7					
	C	C						

* M_0-M_1 disease: 3520 cGy in 22 fx
M_2-M_2 disease: 4000 cGy in 25 fx
** M_0-M_1 disease: posterior fossa boost = 180 cGy in 10 fx
M_2-M_3 disease: posterior fossa boost = 180 cGy in 8 fx

TRT 2: XRT as in Trt 1 ← 3 wks → Post-XRT Chemotherapy

Weeks:	1	2	3	4	5	6	7	11			14			17		
Days:								1	3	4	1	3	4	1	3	4
								P			P			P		
									E	E		E	E		E	E

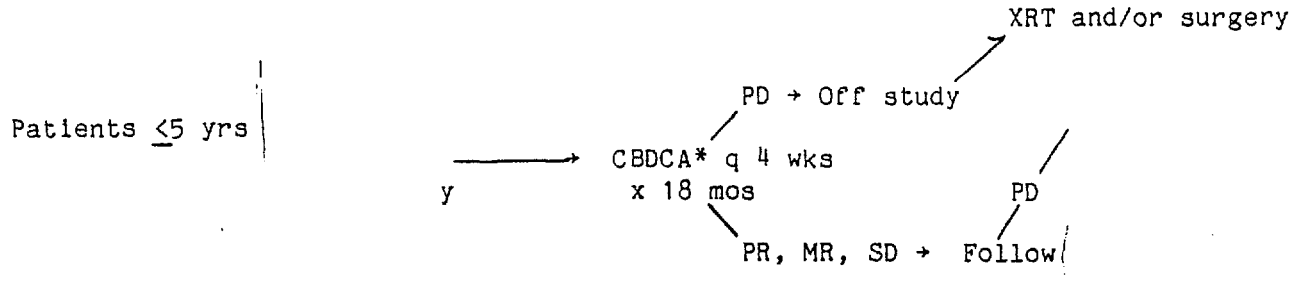
Days:	20	24	28	32	36	40	44	48
	1	2						
	V		Repeat V/C					
	C	C	q 4 weeks x 7					

P = Cisplatin 90 mg/M^2 IV
E = VP-16 150 mg/M^2 IV

V = Vincristine 2 mg/M^2 IV (max 2mg dose)
C = Cyclophosphamide 1000 mg/M^2 IV with Mesna 360 mg/M^2 IV push 15 mins prior to and 3 and 6 hours following cyclophosphamide

Rev. 9/91

Optic pathway Tumors



* Carboplatin 560 mg/M^2 IV over one hour

Courses will continue at 4-week intervals for 18 months, or until there is evidence of progressive disease. Patients developing progressive disease during chemotherapy or subsequently will be treated on POG #8935 with radiation therapy or surgery ± radiation therapy.

Optic Pathway Tumors
PD after Chemo

5.243 The time-dose prescription shall be age dependent:

Age	Fraction Size	Total Dose	Total # fx	Overall time
<36 mos	160 cGy	4640 cGy	29	6 weeks
≥36 mos	180 cGy	5040 cGy	28	6 weeks

5.244 Uniformity Requirement: The minimum dose with the treatment volume may not be less than 4500 cGy for children ≤36 months. In other cases, the maximum variation in dose shall be within +/- 5% of the prescription point as defined in Section 5.2421 or 5.2422. The use of wedges or compensators are encouraged to minimize the variation of radiation dose within the treatment volume.

5.25 Time-Dose Considerations

5.251 The treatment shall be given once daily, five days a week.

5.252 All fields will be treated each day.

5.253 If unscheduled delays of one week or more occur, the treating physician shall contact Dr. Gemer before completion of radiotherapy.

5.254 No TDF time-dose corrections are to be made.

5.26 Normal Tissue Sparing

5.261 Every effort shall be made to exclude the auditory apparatus from the treatment volume whenever possible.

5.262 It is suggested that in essentially all cases, the anterior globe and lens may be excluded from the treatment volume.

5.27 Quality Assurance and Documentation

Data for radiotherapy review must be submitted to QARC, at the address listed in Sec. 5.273, according to the schedule outlined below.

5.271 On-Therapy Review

The items specified below should be submitted within 3 days of the onset of radiotherapy:

- Copies of localizing films (Note: If polaroid or other photographic process is used for the duplication of localizing films and verification films, it is important that these images are of sufficiently good quality for review. It is recommended that photographs of these films be taken at a distance close enough to allow the portal or verification film to fill up the entire polaroid print.)
- Copies of verification films.
- Polaroid pictures of the patient in the treatment position with the fields appropriately marked.
- Radiotherapy Daily Dose Calculation Check (RT-1).

Appendix K.

EQUIPMENT AND MATERIALS PURCHASED WITH USAID FUNDS:

•Accessories to upgrade an existing High Pressure Liquid Chromatography Unit

•Photographic Microscope

•Five Microcomputers

•Two Facsimile Machines

•Laboratory and Technical Software

•Pediatric Gastroscope

•Gastroscope Light

•Electroencephalography Headstage Unit

•Whole Blood Alarm Refrigerator

•Monoclonal Antibodies

•Laboratory glassware and utensils

•Electrosurgical Generator

•Hematologic Analyzer

EQUIPMENT PURCHASED WITH KUMC DONATION TO POOH PROJECT:

•Ford Ambulance

•Sonography Machine

•Accessories to Upgrade and Existing High Pressure Liquid Chromatography Unit

•Eight Pediatric Intensive Care Unit Vital Sign Monitors

•Two Pediatric Respirators

DONATIONS FROM DIRECT RELIEF INTERNATIONAL:

ipment #: 1683- HUNGARY 03/05/96 12:32

ece #	Product Name and Description	Qty.
1	multivitamins Captain Pep Tabs Child Chew 15,000	1
	dextran Liquid 0.6% 12x500ml Expires: 11/30/97	1
	lidocaine/epinephrin Injections 1.5% 40x5ml Expires: 04/30/97	1
	lidocaine/epinephrin Injections 1.5% 25x5ml Expires: 12/31/96	1
	lidocaine/epinephrin Injections 1.5% 30x5ml Expires: 12/31/96	1
	Aspirin tabs 325mg12 x 250's Expires: 10/31/97	2
	acetaminophen Children's Tylenol Tabs Chew 48x30 Expires: 07/31/98	4
	desipramine HCL Norpramin Tabs 10mg 12x100 Expires: 05/30/97	1
	dexamethasone Decadron IV/IM Inj. 4mg/ml 25x1ml Expires: 06/30/97	10
	theophylline Theolair Tabs 250mg 2x100 Expires: 11/30/96	1
	theophylline Theolair Tabs 125mg 6x100 Expires: 12/31/96	1
	theophylline Theolair Tabs 250mg 2x100 Expires: 04/30/97	1
	theophylline Theolair Tabs 125mg&250mg 3x100 Expires: 12/31/96	1
	phenylephrine HCL Dristan Nasal Mist Spray 0.5% 24x30ml Expires: 02/28/97	4
	pseudoephedrine HCL PediaCare Cough/Cold Chew Tabs 15mg 48x16 Expires: 11/30/96	4
	pseudoephedrine PediaCare Elixir 24x4oz. Expires: 07/30/97	2
	dextromethorphan Robitussin Ped cold Liquid 7.5mg/5ml 12x8oz Expires: 12/31/97	2
	amoxicillin Suspension 125mg/5ml 12x200 Expires: 09/30/96	8
	cefazolin sodium Cefizox Case IV/IM 2gram (10x10) Expires: 09/30/96	10
	mebendazole Vermox Chew Tabs 100mg 12x24 Expires: 08/30/99	4
	benzalkonium chlorid Med O Chem Germicidal Solution (gal)	2
	vitamin A & D Ointment (ea) (453.6g) Expires: 01/31/97	4

BEST AVAILABLE COPY

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DIRECT RELIEF INTERNATIONAL
PACKING LIST/COMMERCIAL INVOICE

ipment #: 1683- HUNGARY 03/05/96 12:32

ece #	Product Name and Description	Qty.
1	hydrocortisone Prepcort Cream 0.5% 12x5x1oz.	2
	cyclopentolate HCL Pentolair Ophthalmic Drops 1% 22x15ml Expires: 11/30/96	1
	magaldrate Riopan Plus Tabs 480mg 36x50 Expires: 11/30/96	4
	diatrizoate/meglumin Renografin-76 Liquid 660mgl/ml 25x50ml Expires: 01/01/99	1
	ganciclovir Cytovene 50 vials injection Expires: 05/31/96	2
	metoclopramide IM/IV 10mg/2ml 16x2ml Expires: 03/31/97	1
	Immune GlobulinHuman IV Powder 10x12grams Expires: 05/31/97	1
	First Aid Tape 1/2" Roll (ea)	96
	Elastic Tape 1" Roll (ea)	12
	NonAdhering Dressing DRI Pre-Pack Assortment (36)	1
	Bioclusive Transparent Dressing DRI Pre-Pack Assortment (20)	10
	Clearon Skin Closures (box of 50)	2
	Gauze Bandage 2" Case (96's)	1
	Gauze Bandage (ea) 1" Roll	96
	Gauze Bandages (ea) 3" Roll	107
	orthoptic eye patch Opticlude Junior Patch (20)	20
	Thermometers DRI Pre-Pack (5)&sheaths	1
	Gauze Sponges Not Sterile 2x2 Case	1
	sterile gauze sponge Case (4x4 8-ply) (1440's)	1
	ster. adhesive pads Case (2.25x3in) 24x25	4
	Gauze Pads (25's) Sterile	57
	Burn Dressing Roll (ea)	37
	Surgeon's Gloves Case of 200 pair Size 7 1/2	1

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DIRECT RELIEF INTERNATIONAL
PACKING LIST/COMMERCIAL INVOICE

hipment #: 1683- HUNGARY 03/05/96 12:32

iece #	Product Name and Description	Qty.
1	Surgeon's Gloves Assorted Sizes Sterile (pair)	400
	Surgical Scrub Brush disposable (ea)	100
	Surgical Tape (roll)	60
	Surgical Drain Penrose Assorted Sizes (ea)	150
	Endotrachael Tube Pediatric, disposable (ea)	100
	Ice Bag (ea)	5
	Administration Set Blood	56
	Pediatric Feed Tube PEDIATRIC - each	100
	Trocar/Thoracic Catheter	20
	Syringe, Hypodermic disposable, with needle	1000
	Syringe, Hypodermic Glass, with Needle DRI Pre-Pack Assortment (10)	1
	PDR Physician's Desk Reference	1
	youth toothbrushes each	1
	Baby Powder corn starch Case (48x9oz)	1

PIECE # 1

Gross Weight	705 lbs	320 kg.
Net Weight	648 lbs	294 kg.
Length	55.2 in.	140 cm.
Width	44.4 in.	113 cm.
Height	44.4 in.	113 cm.
Volume	63.0 cu.ft.	1.78 cu.Mtr.

5

DIRECT RELIEF INTERNATIONAL
PACKING LIST/COMMERCIAL INVOICE

Shipment #: 1363-PS HUNGARY

02/24/95 07:10

Piece #	Product Name Desc. Stock-ID	Qty.	Value (U.S $)
1	hydrochlorothiazide Tabs 50mg 15x100	1	$56.25
	multivitamins Trinsicon Caps 240mg 12x500	1	$2,956.52
	multivitamins Children's Chevable Tabs Bulk 18,000	1	$270.00
	bupivacaine HCL Marcaine Injection 0.75% 10x10ml	3	$1,086.36
	doxepin HCL Solution 10mg/ml 12x4oz	1	$192.00
	prednisone Suspension 50mg/ml 10x30ml	1	$171.00
	prednisone Tabs 5mg 1000's	2	$48.00
	theophylline Tabs 1000's	3	$465.00
	Bronkotabs Tabs 5x100	1	$235.70
	gentamycin sulfate Liquid 14x2ml	1	$24.50
	sulfamethoxazole Sulfatrim Suspension 200mg/40mg 473ml	21	$258.30
	magaldrate Riopan Plus Tabs 480mg 36x100	2	$301.56
	magaldrate Riopan Plus DS Liquid 12x12oz	2	$132.76
	glycerin suppository suppositories 22x100	1	$90.20

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6

DIRECT RELIEF INTERNATIONAL
PACKING LIST/COMMERCIAL INVOICE

Shipment #: 1363-PS HUNGARY

02/24/95 07:10

Piece #	Product Name Desc. Stock-ID	Qty.	Value (U.S $)
1	bisacodyl Dulcagen Suppositories 10mg 3x100	1	$37.44
	senna concentrate Senna-Gen tabs 187mg 1000	1	$17.25
	bisacodyl Dacodyl Suppositories 10mg 9x100	1	$129.15
	mepenzolate bromide Cantil Tabs 25mg 12x100	3	$2,680.56
	methotrexate Tabs 2.5mg 10x100	1	$2,790.00
	Scalpel Blades DRI Pre-Pack Assortment(100)	1	$39.90
	Administration Set IV, Primary	100	$290.00
	IV Catheter, long	50	$179.00
	IV Catheters and Infusion Sets DRI Pre-Pack Assortment (50)	2	$152.30
	Urinary Catheters DRI Pre-Pack Assortment (20)	3	$105.00
	Urine Drainage bags and tubes	42	$132.30
	Suction Catheter Pre-Pack Assortment (12)	5	$75.00
	Trocar/Thoracic Catheter	20	$120.00
	Syringe, Hypodermic Glass	50	$160.00

521

DIRECT RELIEF INTERNATIONAL
PACKING LIST/COMMERCIAL INVOICE

Shipment #: 1363-PS HUNGARY 02/24/95 07:10

Piece #	Product Name Desc. Stock-ID	Qty.	Value (U.S $)
1	Syringe, Hypodermic disposable, with needle	500	$155.00
	Syringes/needles DRI PrePack Assortment (100)	2	$62.00
	Needles, Hypodermic assorted sizes disposable (100's)	5	$49.75
	Needle, Spinal assorted sizes disposable	200	$40.00
	Needle, Biopsy	50	$17.50
	Instrument Tray metal (ea)	2	$39.90
	Latex Exam Gloves small/medium Box of 100 Single Gloves	5	$41.95
	Latex Exam Gloves medium/large Box of 100 Single Gloves	5	$41.95

PIECE # 1 Total Value in U.S. $ $13,644.10

Gross Weight	308 lbs	140 kg.
Net Weight	258 lbs	117 kg.
Length	36.0 in.	91 cm.
Width	28.8 in.	73 cm.
Height	31.2 in.	79 cm.
Volume	18.7 cu.ft.	0.53 cu.Mtr.

Piece #	Product Name Desc. Stock-ID	Qty.	Value (U.S $)
2	acetaminophen Supp. 120mg 24x12	1	$118.80
	acetaminophen Children's Tylenol Chewable Tabs 48x30	6	$797.76

DIRECT RELIEF INTERNATIONAL
PACKING LIST/COMMERCIAL INVOICE

Shipment #: 1363-PS HUNGARY 02/24/95 07:10

Piece #	Product Name Desc. Stock-ID	Qty.	Value (U.S $)
2	acetaminophen Infant Tylenol Drops 80mg/.8ml 36x30ml	4	$933.12
	acetaminophen	3	$300.00

Case of 12x8oz. bottles		
corn starch Baby Powder Case 48x9oz	3	$86.40
Toothbrush, Adult Reach Pre-Pack (288)	2	$720.00
Youth Toothbrushes Case (72's)	10	$900.00
Baby Shampoo Liquid 24x7fl.oz (case)	10	$720.00
Baby Wash Cloths 12x120 Packs	7	$252.00
Baby Wash Cloths Drop in Refill Pack Case	3	$216.00
Baby Lotion 24x12 fl oz bottles	2	$144.00

PIECE # 2 Total Value in U.S. $ $5,438.08

Gross Weight	920 lbs	417 kg.
Net Weight	869 lbs	394 kg.
Length	48.0 in.	122 cm.
Width	43.2 in.	110 cm.
Height	46.8 in.	119 cm.
Volume	56.2 cu.ft.	1.59 cu.Mtr.

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DIRECT RELIEF INTERNATIONAL
PACKING LIST/COMMERCIAL INVOICE

hipment #: 1362-S HUNGARY

02/24/95 09:16

Piece #	Product Name Desc. Stock-ID	Qty.	Value (U.S $)
1	Antiseptic Wipes (100's)	5	$13.50
	Bioclusive Transparent Dressing (ea)	300	$477.00
	Thermometers DRI Pre-Pack (5)&sheaths	5	$50.00
	Sutures, Ethilon 1 unit = 1 dozen sutures	2	$68.44
	Sutures, Mersiline 1 unit = 1 dozen sutures	10	$250.00
	Sutures, Prolene 1 unit = 1 dozen sutures	10	$489.90
	Sutures DRI Pre-Pack Assortment (60)	3	$420.00
	Surgical Instruments Neurosurgery	50	$10,250.00
	Embolism Stocking Assorted Sizes	100	$300.00
	Ice Bag	10	$46.00
	Urine Catheter Assorted Sizes & Types	100	$175.00
	Urine Drainage bags and tubes	50	$157.50
	Suction Catheter Pre-Pack Assortment (12)	10	$150.00
	Central Vein Pressure (CVP) Supplies	5	$100.00
	Monitoring Kit arterial	5	$60.00
	Emesis Basin plastic	20	$40.00

DIRECT RELIEF INTERNATIONAL
PACKING LIST/COMMERCIAL INVOICE

Shipment #: 1362-S HUNGARY 02/24/95 09:16

Piece #	Product Name Desc. Stock-ID	Qty.	Value (U.S $)
1	Wash Basin, plastic	20	$26.00
	Dressing Bowl	15	$60.00
	Stainless Steel Tray	5	$399.75
	Hospital Bed Sheet Cloth (ea)	30	$180.00
	Hospital Pillow Case Cloth (ea)	60	$135.00
	toothbrushes adult Reach Toothbrushes each	432	$540.00

PIECE # 1 Total Value in U.S. $ $14,388.09

Gross Weight	200 lbs	91 kg.
Net Weight	187 lbs	85 kg.
Length	37.2 in.	94 cm.
Width	28.8 in.	73 cm.
Height	31.2 in.	79 cm.
Volume	19.3 cu.ft.	0.55 cu.Mtr.

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Appendix L.

MEDICAL BOOKS AND JOURNALS PURCHASED BY THE POOH PROJECT:

Journals:

1. Journal of Pediatric Gastroenterology & Nutrition
2. Oncology News International
3. Current Contents - Life Sciences (for CDROM)
4. Current Contents - Clinical Medicine (for CDROM)
5. Pediatric Neurosurgery
6. Cerebrovascular & Brain Metabolism
7. Perspectives in Neurological Surgery
8. Developmental Medicine and Child Neurology

Medical Text Books:

1. Atlas of Neuropathology
2. SAS Computer Software Manuals
3. SNOMED, Pathology Manual
4. Clinical Neuroanesthesia
5. Neurobiology of Brain Tumors
6. Imaging Techniques of CNS
7. Pediatric Neurology
8. Color Atlas of Brain Disorders
9. Intracranial Aneurysm Surgery
10. Textbook of Childhood Neurology
11. Meningiomas
12. Cerebral Sinus Thrombosis
13. Surgical Techniques for Saccullar & GIA
14. Head Injuries in the Newborn & Infant
15. Surgery of Sellar Region & Paranasal
16. Treatment of Infantile Hydrocephalus
17. International Classification of Diseases for Oncology
18. International Disease Classification IDC-9-CM
19. Atlas of Magnetic Resonance Imaging of the Brain
20. MR/CT Imaging of Head, Neck, Spine
21. Magnetic Resonance Imaging of Children
22. Pediatric Neurology, Principles & Practice
23. Fetal and Perinatal Neurology
24. Diagnostic Flow Cytometer
25. Late Effects of Treatment for Cancer
26. Soft Tissue Tumors
27. Tumours of the Nervous System
28. Nelson Textbook of Pediatrics

29. Tumor Stereotaxis
30. Hematology of Infancy & Childhood
31. Clinical Management of Poisoning & Drug Overdose
32. Pediatric Gastrenterology Disease
33. Hematology: Basic Principles & Practice
34. Jawetz's Medical Microbiology
35. Adult & Pediatric Urology, 2 vol.
36. Current Pediatric Diagnosis & Treatment
37. Handbook of Pediatrics
38. Handbook of Pediatric Drug Therapy
39. Clinical Imaging: An Atlas of Differential Diagnostics
40. Textbook of Diagnostic Ultrasonography
41. Surgical Diagnosis & Treatment
42. Trauma: Anesthesia & Intensive Care
43. Manual of Skin Disease
44. Recommended Dietary Allowances
45. Basic & Clinical Endocrinology
46. Pharmacological Basics
47. PCP Protocols: A Guide to Methods & Applications
48. Textbook of Hematology
49. Principles of Practice in Pediatric Oncology
50. Molecular Cloning: A Laboratory Manual
51. Kendigs Disorders of the Respiratory Tract
52. Catalog of Teratogenic Agents
53. Chromosomes in Human Cancer & Leukemia
54. Allergy, 2 vol.
55. Clinical Pediatric Oncology
56. Modern Nutrition Health & Disease
57. Long-Term Complications of Therapy
58. Molecular Genetics
59. Common Food Intolerances 1: Epidemiology of Coeliac Disease
60. Common Food Intolerances 2: Milk & Human Nutrition
61. Beyond Defeciency: New Views on Function & Health Effects of Vitamins
62. Pediatric Secrets
63. Atlas of Normal Roentgen Variants that may Simulate Disease
64. Cancer Chemotherapy, Princciple & Practice
65. Pediatric Critical Care
66. Hematology of Infancy & Childhood
67. Practical Pediatrics Oncology
68. Oxford Textbook of Clinical Pharmacology
69. Principles & Practice in Pediatric Oncology
70. Catalog of Prenatally Diagnosed Conditions
71. Pysicians Desk Reference
72. Dorlands Medical Dictionary

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73. Pediatric Gastroenterology
74. Nutrition During Infancy
75. Cancer & Nutrition
76. Feeding the Sick Infant
77. Important Advances in Oncology
78. Cancer Principles & Practice, vol. 2
79. Vascular Access in the Cancer Patient
80. Physiology of the Gastrenterological Tract
81. Clinical Endocrinology
82. Nursing Care of Children with Cancer
83. Hematology of Infancy & Childhood
84. Cardiac Toxiccity after Childhood Cancer
85. The Large Intestine
86. Supportive Care of Children
87. Coeliac Disease
88. Modern Nutrition in Health & Disease
89. Manual of Nutrition Therapeautics
90. Pediatric Gastointestinal Disease
91. The Basic Science of Oncology
92. Applied Biopharmaceutics & Pharmaconetics
93. Handbook of Nursing Diagnosis
94. Nursing Diagnoses with Intervention, 3rd ed.
95. Mosky's Nursing Drug Reference, 1992
96. Pediatric Medications
97. Handbook of Drugs for Nursing Practice

JOURNALS DONATED TO SDP AND NINS:

1. CA Journal for Clinicans
2. Journal of Oncology Management
3. Infections in Medicine
4. Academic Physician & Scientist
5. Journal of American Blood Research Association
6. Pediatrics
7. Monographs, Journal of the National Cancer Institute
8. Cancer Investigation
9. Oncology
10. Blood, Journal of the american Society of Hematology
11. Cancer Control
12. Cancer, Journal of the American Cancer Society
13. Journal of Clinical Oncology
14. International Pediatrics
15. Hematology/Oncology Annals
16. Oncology Times

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17. Oncology Issues, Association of Community Cancer Centers
18. International Pediatrics
19. AAP News, American Academy of Pediatrics
20. New England Journal of Medicine
21. International Journal of Radiation Oncology*

*Current subscription donated by Dr. Richard Evans, KUMC, Radiation Oncology

FIRST ANNUAL WINNIE - THE - POOH SYMPOSIUM

ON CHILDHOOD MALIGNANCIES

3-4 AUGUST 1992

BUDAPEST, HUNGARY

MONDAY 3 AUGUST — **DAY ONE - PEDIATRIC CNS TUMORS**

Presiding: Prof. dr. Emil Pásztor

TIME	TOPIC	SPEAKER
9:00	Magnitude of the Problem	F. Hölmes
9:30	Pituitary Adenomas in Children	F. Slowik, E. Pásztor I. Fazekas K. Balint
10:00	Rhabdoid Tumors of the CNS	J. Kepes
10:30	Morning Coffee	
11:00	Experiences in the Management of Infratentorial Tumors in Infancy and Childhood	E. Paraicz
11:30	Imaging of CNS Tumors of Infants and Children	S. Batnitzky
12:00	Management of Pineal Region Tumors	S. Czirjak J. Vajda E. Pásztor
12:30	Luncheon	

Presiding: Dr. Istvan Nyary

14:00	Radiotherapy of Childhood Brain Tumors	R. Evans
14:30	Neurosurgical Aspects of Spinal Neuroblastomas	M. Kordas F. Slowik J. Kisban S. Czirjak O. Major
15:00	Chemotherapy of Brain Tumors in the Young	T. Vats
15:30	Afternoon Tea	
16:00	Very Long Follow-Up of Young Brain Tumor Patients	G. Holmes
16:30	A Database for Childhood CNS Tumors	D. Zamaroczy
17:00	Discussion	

TUESDAY 4 AUGUST

DAY TWO - OTHER CHILDHOOD MALIGNANCIES

TIME	TOPIC	SPEAKER(S)
Presiding : Prof. dr. Deszo Schuler		
9:00	Clinical Pharmacology Research in Pediatric Oncology	J. Borsi D. Schuler
9:30	Diagnostic Imaging of Childhood Spinal Tumors	S. Batnitzky
10:00	Radiotherapy of Childhood Bone Tumors	R. Evans
10:30	Morning Coffee	
11:00	Chemotherapy of Childhood Bone Tumors	T. Vats
11:30	Osteosarcoma Therapy and Its Side Effects	D. Schuler R. Koós C. Czáky J. Borsi
12:00	Luncheon	

Presiding: Dr. Joseph Borsi

14:00	Wernicke Encephalopathy in Two Children with Malignant Diseases	R. Kálmánchey K. Majtényi R. Koós J. Borsi D. Schuler
14:30	New Brain Tumor Entities in Children and Adolescents	J. Kepes
15:00	The Personal and Social Cost of Curing Childhood Malignancies	F. Hölmes
15:30	Afternoon Tea	
16:00	A Database for Childhood Bone Tumors	E. Apjok
16:30	Discussion - Suggested Topics 1.Minimal panels of monoclonal antibodies recommended for immunological diagnosis 2.Minimal databases for the various tumors 3.Bone marrow transplantation	

Appendix Mb.

The University of Kansas Medical Center
Office of Continuing Education
3901 Rainbow Blvd.
Kansas City, KS 66160-7108

2nd Annual

Winnie-the-Pooh Symposium on Pediatric Malignancies

Wednesday, October 13, 1993

Westin Crown Center Hotel
One Pershing Road
Kansas City, Missouri

KU Medical Center

Pediatric Oncology Outreach to Hungary Program

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Program Agenda

7:00 a.m.	Registration and Continental Breakfast
7:55 a.m.	Welcome and Introduction Frederick F. Holmes, MD
	Moderator: Frederick F. Holmes, MD
8:00 a.m.	**Special Brain Surgery Techniques for Infants** Ervin Paraicz, MD, PhD; Eszter Kónya, MD; Mária Korenchy, MD
8:30 a.m.	**Late Effects of Radiotherapy on the Brain** Raymond K. Mulhern, PhD
9:00 a.m.	**Combined Modality Treatment of Brain Tumors** Tribhawan Vats, MD
9:30 a.m.	**New Concepts Related to the Interpretation of the Histology of Brain Tumors** John J. Kepes, MD; Felicia Slowik, MD
10:00 a.m.	Refreshments
10:15 a.m.	**Brainstem Tumor Surgery** István Nyáry, MD, PhD; Ervin Paraicz, MD, PhD; Katalin Tóth, MD
10:45 a.m.	**Transoral and Transsphenoidal Pediatric Surgery** Emil Pásztor, MD; Ilona Dobronyi, MD
11:15 a.m.	**Role Development of the Pediatric Oncology Nurse Clinician** Pamela Cummings, RN, BSN
11:45 a.m.	**Nursing's Role in Supportive Care of Pediatric Oncology Patients** Susan Tobin, RN, MA, CPNP
12:15 p.m.	Adjourn to Lunch
12:30 p.m.-1:30 p.m.	Roundtable Discussions of Cancer in Hungary
	Table 1 Topic: Nutrition in Pediatric Cancer, Hedvig Bodánszky, MD, PhD, facilitator
	Table 2 Topic: Immunologic Phenotyping, Valéria Klujber, MD, facilitator
	Table 3 Topic: The Late Effects and Incidence of Pediatric Cancer, Dezsö Schuler, MD, PhD, Csilla Csáki, MD, facilitators
	Table 4 Topic: Wilms Tumor Trials, Pál Kajtár, MD, PhD, facilitator
	Table 5 Topic: AML Therapy, Péter Masath, MD, Zsuzsa Béres, MD, facilitators
	Table 6 Topic: The Use of Cytokines, Joseph D. Borsi, MD, PhD, Thomas Ferencz, MD, facilitators
	Table 7 Topic: Organization of Neurosurgery, Emil Pásztor, MD, facilitator
	Table 8 Topic: The Role of Electrophysiology in Pediatric Oncology, Katalin Tóth, MD, facilitator
1:45 p.m.	**European Perspective on Aggressive Treatment of Hodgkin's Disease** Pál Kajtár, MD, PhD
2:15 p.m.	**American Perspective on Aggressive Treatment of Hodgkin's Disease** Tribhawan Vats, MD
2:45 p.m.	**European Perspective on Therapy for High-Risk Neuroblastoma** Dezsö Schuler, MD, PhD
3:15 p.m.	Refreshments
3:30 p.m.	**American Perspective on Therapy for High-Risk Neuroblastoma** Abbas Emami, MD
4:00 p.m.	**The Role of the Pediatric Oncology Nurse in Hungary** Andrea Zafir, Pediatric Nurse Clinician; Erzsébet Nehéz, Surgical Nurse Clinician
4:30 p.m.	**European Perspective on New Drugs in Pediatric Oncology** Joseph D. Borsi, MD, PhD
4:50 p.m.	**American Perspective on New Drugs in Pediatric Oncology** Robert Trueworthy, MD
5:10 p.m.	**Summary and Evaluation** Frederick F. Holmes, MD
5:20 p.m.	Adjourn

Faculty

University of Kansas Medical Center, Kansas City, Kan.
Pamela Cummings, RN, BSN, Nurse Clinician, Dept. of Pediatrics, Division of Hematology/Oncology.
Abbas Emami, MD, Associate Professor, Dept. of Pediatrics, Division of Hematology/Oncology.

Frederick F. Holmes, MD, Edward Hashinger Distinguished Professor; Principal Investigator, POOH Program.
John J. Kepes, MD, Professor Emeritus, Dept. of Pathology and Laboratory Medicine; Co-Investigator, POOH Program.
Susan Tobin, RN, MA, CPNP, Clinical Nurse Specialist, Dept. of Pediatrics, Division of Hematology/Oncology.
Robert Trueworthy, MD, Professor, Dept. of Pediatrics, Division of Hematology/Oncology.
Tribhawan Vats, MD, Professor, Dept. of Pediatrics; Director, Division of Hematology/Oncology; Co-Investigator, POOH Program.

Guests
Raymond K. Mulhern, PhD, Director, Divisions of Psychology and Behavioral Medicine, St. Jude Children's Research Hospital, Memphis, Tenn.

National Institute of Neurosurgery (NINS), Budapest, Hungary
Ilona Dobronyi, MD, Pediatric Neurologist.
Eszter Kónya, MD, Pediatric Neurologist.
Mária Korenchy, MD, Pediatric Neurologist.
Erzsébet Nehéz, Surgical Nurse Clinician.
István Nyáry, MD, PhD, Professor and Director (NINS), Co-Investigator, POOH Program.
Ervin Paraicz, MD, PhD, Chief, Pediatric Neurosurgery.
Emil Pásztor, MD, Professor, Director Emeritus (NINS), Co-Investigator, POOH Program.
Felicia Slowik, MD, Chief, Pathology.
Katalin Tóth, MD, Pediatric Neurologist.

Second Dept. of Pediatrics (SDP)
Semmelweis University Medical School
Budapest, Hungary
Zsuzsa Béres, MD, Secretary of the Committee for Bone Marrow Transplantation.
Hedvig Bodánszky, MD, PhD, Associate Professor, Pediatric Gastroenterology.
Joseph D. Borsi, MD, PhD, Associate Professor; Chief, Pediatric Oncology; Chief, Chemotherapy and Pharmacology; Co-Investigator, POOH Program.
Csilla Csáki, MD, Clinical Research Fellow.
Thomas Ferencz, MD, Clinical Research Fellow.
Pál Kajtár, MD, PhD, Associate Professor; Director, Regional Pediatric Oncology Center of Southwest Hungary.
Valéria Klujber, MD, Immunologist.
Péter Masath, MD, Markusovszky Teaching Hospital; Member, Hungarian Pediatric Oncology Group.
Dezsö Schuler, MD, PhD, Professor; Director (SDP); Director, National Institute of Child Health in Hungary; Co-Investigator, POOH Program.
Andrea Zafir, Pediatric Nurse Clinician.

REGISTRATION FORM
2nd Annual Winnie-the-Pooh Symposium on Pediatric Malignancies
Wednesday, October 13, 1993

Name _____
Last First Middle
(Nurses must use their legal names as filed with the state board of nursing.)

☐MD ☐DO ☐RN ☐Other (please specify): _____

Address _____

City _____ State _____ Zip Code _____ KS County _____

Daytime Phone _____ Professional License No. _____

Roundtable Discussions: (rank in order of preference) Table 1_____ Table 2_____ Table 3_____ Table 4_____ Table 5_____ Table 6_____ Table 7_____ Table 8_____

Registration Fees:
$25 for all participants
☐Check enclosed (payable to KU Medical Center)
Charge fee to: ☐Mastercard ☐VISA

Account No. _____

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Signature _____

Please specify: _____

Return this form with payment to the Office of Continuing Education, KU Medical Center, 3901 Rainbow Blvd., Kansas City, KS 66160-7108. Register by phone with your credit card at (913) 588-4488; fax (913) 588-4486.

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Overview

The mortality of children with cancer in Hungary exceeds that of children with cancer in the United States. This is true for acute leukemia, brain tumors and other solid tumors. Because the frequency and types of cancer in the two populations are the same, the excess deaths in Hungary may be preventable. This symposium will bring together American and Hungarian physicians and nurses to share knowledge and compare experiences in the hope of improving the mortality rates of children who suffer from cancer in both countries. **All sessions will be conducted in English.**

The Pediatric Oncology Outreach to Hungary (POOH) Program is a partnership among the University of Kansas Medical Center's Cancer Center, the National Institute of Neurosurgery, and the Second Department of Pediatrics of the Semmelweis University Medical School in Budapest, Hungary. The POOH Program is supported by a grant from the Agency for International Development of the U.S. State Department.

Target Audience

This symposium is designed for oncologists, neurosurgeons, neurologists, pediatricians, pediatric nurses, and all other physicians and nurses with an interest in international health.

Objectives

Upon completion of this symposium, participants will be able to: (1) compare American and European treatment for advanced Hodgkin's disease, high-risk neuroblastoma, and brain tumors in pediatric patients; (2) discuss new diagnostic methods of histopathological evaluation of brain tumors and their prognoses; (3) examine the role of the pediatric oncology nurse clinician in the United States and Hungary in the care of children with cancer; and (4) review selected issues of health care delivery in Hungary.

Accreditation

Physicians. The University of Kansas Medical Center (KUMC) Office of Continuing Education is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing education for physicians.

This course is designated for 8 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Nurses. This offering for 10 contact hours is sponsored by the University of Kansas School of Nursing Office of Continuing Nursing Education, which is accredited as a provider of continuing education in nursing by the American Nurses Credentialing Center's Commission on Accreditation and approved by the Kansas State Board of Nursing (Provider#LT0080-0927).

All participants must sign attendance rosters. A $5 fee will be assessed to duplicate or replace credit certificates.

Planning Committee

Ariel Baker, BS; David Baldwin, MPA; Joseph D. Borsi, MD, PhD; Pamela Cummings, RN, BSN; Carmen Jacobs, RN, MEd, MBA; Frederick F. Holmes, MD; John J. Kepes, MD; Istvan Nyáry, MD, PhD; Emil Pásztor, MD; Dezsö Schuler, MD, PhD; and Tribhawan Vats, MD.

Registration and Fees

Fees include course materials, refreshments, lunch, and records of attendance. Lunch will be guaranteed only to those registering by **Oct. 8, 1993.**

Physicians	$25
Nurses	$25
Residents, Students	$25

A $15 fee will be assessed for cancellations on or before **Oct. 8, 1993**, and for returned checks. No refunds will be made after this date. KUMC reserves the right to cancel all programs and return all fees. The liability of KUMC is limited to the course fee. KUMC will not be responsible for any losses incurred by registrants, including but not limited to airline cancellation charges or hotel deposits.

Program Accessibility

We provide accommodations to people with disabilities. Please call (913) 588-4488 for more information, or mark the space indicated on the registration form. To assure accommodation, please register at least two weeks before the date of the symposium.

The University of Kansas is committed to providing programs and activities to all persons regardless of race, religion, color, sex, disability, national origin, ancestry, sexual orientation, marital or parental status and, to the extent covered by the law, age or veteran status.

Hotel Accommodations

All symposium activities will take place at the Westin Crown Center Hotel, One Pershing Road, Kansas City, Mo. Free covered parking is available. A block of rooms at special rates has been reserved for conference participants. To make reservations, call (816) 474-4400.

The Westin is a luxury hotel that has convenient access to the shops, restaurants, cinema, and live theater in the Crown Center shopping complex.

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ıetőség a SEPSIS terápiájában

aktivált, intravénás, IgM-tartalmú immunglobulin

·tel: 1 ml oldat tartalma: 50 mg fehérje, melynek legalább humán immunglobulin (IgM 6 mg, IgA 6 mg, IgG 38 mg) ; glucose monohydrat.

:
ıs bakteriális fertőzések terápiája egyidejű antibiotikum-éssel:
ıikaemia, septicus shock korai fázisa
ıszülöttek, újszülöttek sepsise
nyes agyhártyagyulladás
ınglobulinsubstitutio immunsupprimált és súlyos secundaer st-hiányos állapotokban.

allat: Ismert túlérzékenység humán immunglobulinokra.

ıatások: Az infusio adása alatt vagy után átmeneti ıklet-emelkedés, bőrreakciók vagy szubjektív panaszok tnek. Ritkán anaphylaxiás reakciók is lehetségesek.

zerkölcsönhatások: A Pentaglobin beadása után 3 hónapig svakcina (*mumps, morbilli, rubeola, sárgaláz*) *nem* adható. nőknek calciumgluconáttal való együttadása kerülendő, ·mkívánatos reakciók léphetnek fel.

ıs: Sepsis kezelésére 5 ml/tskg/24 óra 3 egymást követő ı, de a klinikai állapottól függően további adagolására is lehet.

lés: 10 és 20 ml ampulla, 50 és 100 ml-es infusio.
övelt IgA- és különösen IgM-tartalom folytán a Pentaglobin a G-készítményekkel összehasonlítva jelentősen magasabb eriális és endo/exotoxin ellenes titerrel rendelkezik.

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Appendix Mc.

A MAGYAR GYERMEKORVOSOK TÁRSASÁGA GYERMEKONKOLÓGIAI MUNKACSOPORTJÁNAK Tudományos Ülése

1994

Lillafüred
Hotel Palota

ÁLTALÁNOS TUDNIVALÓK:

Irásvetítő, kettős dia-, videofilm vetítési lehetőség biztosított. A Budapestről 14.47-kor Miskolc Tiszai pályaudvarra érkezőket az állomás előtti parkolóban várjuk és mikrobusszal Lillafüredre szállítjuk.

Ugyancsak mikrobuszt biztosítunk a szombaton 16.00 órakor induló Miskolc - Budapest Intercity-vel utazni szándékozóknak.
A más irányból vonattal utazókat kérjük, szíveskedjenek érkezésük pontos időpontját levélben közölni, hogy a pályaudvarról kocsival való szállításukról gondoskodhassunk.
A Lillafüredi Palotaszálló az állomás elől induló 1. számú autóbusszal, egy átszállással (a Majális Parkból az 5. számú busszal) megközelíthető.
Az utazás időtartama így kb. 1 óra.

SZPONZOROK NÉVSORA

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BIOGAL Gyógyszergyár RT.
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SANDOZ PHARMA
PFIZER-BIOGAL
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Boehringer Mannheim
STERLING HEALTH
SCHERING-PLOUGH
PALL PROMEDICO AG.
Interpharma KFT.
WELCOME EAST EUROPA LTD.

09.10 - 09.30 A diagnosztikus vizsgálatok értékelése daganatos gyermekek kórszövettani leleteinek elemzése során
Prof. Dr. Szende Béla (SOTE)

09.30 - 09.45 Beszámoló az AML tanulmányról
Dr. Masát Péter (Szombathely)

09.45 - 10.00 Beszámoló a Wilms tumor tanulmányról
Dr. Kajtár Pál (DOTE)

10.00 - 10.15 Szünet

Üléselnök: Prof. Dr. Oláh É

10.15 - 10.30 Különös esemény ALL fenntartó kezelés során
Dr. Bartyik Katalin, Dr. Krenács László,
Dr. Slanka Tamás, Dr. Virág István (SZOTE, DOTE)

10.30 - 10.45 Non-Hodgkin lymphoma fenotípusának változása a kezelés során
Dr. Magyarossy Edina, Dr. Debreceni Judit, Dr. Maro
Anikó, Dr. Zimonyi Ilona (Heim Pál Gyermekkórház)

10.45 - 11.00 Ismételt telecobalt irradiáció kedvező hatása kemoterá
rezisztens medulloblastoma esetében
Dr. Miltényi László, Dr. Pál I., Dr. Tóth I., Dr. Jakab
Dr. Lugosi Éva, Dr. Oláh Éva, Dr. Kovács Ilona,
Dr. Kiss Csongor (DOTE)

11.00 - 12.00 "Belly - Várlak otthon a paradicsomban"
A malignus betegségben szenvedő gyermek életéről sz
könyvet a szerző ismerteti

12.00 - 12.15 A surveillance tenyésztések értéke csontvelő transzpla
gyermekekben
Dr. Kriván Gergely, Dr. Nikolova Radka,
Dr. Tímár László (Bp., Szent László Kórház)

12.15 - 12.30	Gombás infekciók prevenciója és terápiája malignus haematológiai betegeknél Dr. Kiss Klára, Dr. Hunyadi Katalin, Dr. Nagy Kálmán, Dr. Simkó Róbert, Dr. Vértesi Gabriella (Miskolc)
12.30 - 12.45	A POTE Gyermekonkológiai Központ 15 éves beteganyaga Dr. Kajtár Pál, Dr. Kardos Mária, Dr. Szűcs Rozália (POTE)
12.45 - 13.00	CNS tumoros gyermekek kezelésében szerzett tapasztalataink 1988 - 1994 között Dr. Kisbán Judit, Dr. Pácz Ferenc, Dr. Tirtl Anna (Bethesda Gyermekkórház)
13.00 - 13.15	Megakaryocyta leukaemia sejtvonal (MOe7) sejtfelszíni markereinek és génexpressziójának modulálása cytokin kezeléssel Dr. Kiss Csongor (DOTE)
13.15 - 13.30	Vita
13.45	Ebéd
14.30	Kirándulás Sárospatakra
kb. 20.00	Vacsora a BIOTEST AG támogatásával

1994. május 28. szombat **Üléselnök: Prof. Dr. Schuler Dezső**

08.30 - 09.00	Langerhans Cell Histiocytosis. History and Present Status: Still "X" Dr. John Kepes
09.30 - 10.00	Recent Advances in the Treatment of Langerhans Histiocytosis Dr. Tribhawan Vats
10.00 - 10.30	The Role of Radiation Therapy in the Management of Langerhans Histiocytosis Dr. Richard Evans
10.30 - 11.00	Vita

Üléselnök: Dr. Frederick Holme

11.00 - 11.15	Surgical Treatment of Paediatric Brain Tumors Dr. Nyári István
11.15 - 11.30	Chemotherapy in Paediatric Brain Tumors Dr. Borsi József
11.30 - 12.00	The Emerging Role of Chemotherapy in the Treatment of Medulloblastoma and Malignant Gliomas Dr. Tribhawan Vats
12.00 - 12.30	Hyperfractionated Radiotherapy in Brain Tumors Dr. Richard Evans
12.30	Vita
13.00	Ebéd
14.00 - 14.30	The POOH Project: From the Beginning Dr. Frederick Holmes
14.30 - 15.00	Panel discussion

PROGRAM

1994. május 26. csütörtök **Üléselnök: Dr. Zimonyi Ilona**

17.00 - 17.20	1993. évi leukaemias betegek cytogenetikai vizsgálatainak értékelése, megoldandó feladatok Prof. Dr. Oláh Éva (DOTE)
17.20 - 17.40	1993. évben diagnosztizált leukaemias betegek immunológiai vizsgálatainak elemzése Dr. Klujber Valéria (SOTE)
17.40 - 18.40	1993. évi elvesztett ALL-es és AML-es betegeink esetmegbeszélése Dr. Zimonyi Ilona (Heim Pál Gyermekkórház)
18.00 - 19.00	Beszámoló a berlini BFM megbeszélésről
20.00	Vacsora

1994. május 27. péntek **Üléselnök: Prof. Dr. Virág István**

08.00 - 08.20	1993. évi onkológiai beteganyagok statisztikai elemzése Dr. Apjok Enikő (SOTE)
08.20 - 08.40	Bakteriológiai vizsgálatok malignus haematológiai betegek infekcióiban Dr. Fazakas Eszter (SOTE)
08.40 - 08.55	Gyógytornász szerepe daganatos gyermekek rehabilitációjában Burján Katalin
08.55 - 09.10	Az oktatás jelentősége gyermekonkológiai osztályon Tímár Györgyi

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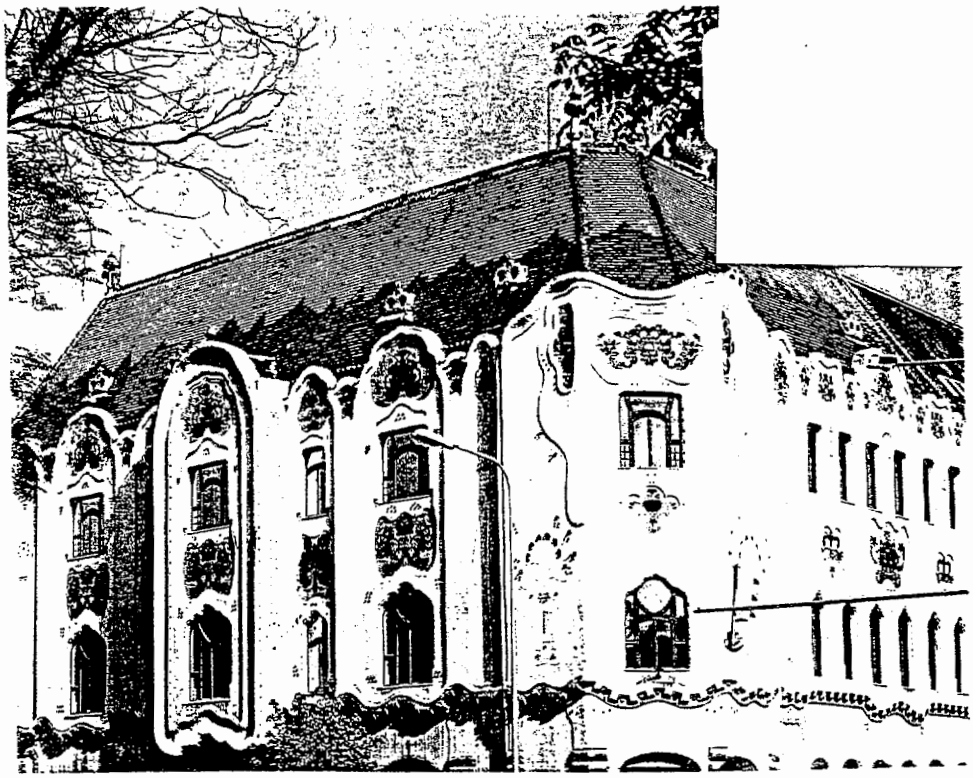

International Congress

of the

Hungarian Society for Pediatric
Neurology, Neurosurgery,
Child and Adolescent Psychiatry

Kecskemét (Hungary)

14-16 May, 1995

Meals:

Breakfast: at place of accommodation (included in room price in hotels; on individual request in pensions)

Lunch: Hotel "Aranyhomok", Kecskemét, Széchenyi tér 2.

Welcome Party: Café Liberté, Kecskemét, Szabadság tér 2.

Farm party: Új Tanya Csárda, Lajosmizse

There will be a buffet open all day long on the entrance floor of the House of Science and Technology.

Organisers:

In the lounge cf the House of Science and Technology, from 2 pm on 14th May, 1995 until the end of the conference.

Please, contact the organisers before you check in at your place of accommodation.

Programs

14th May, 1995

18.00	Organ concert *(Kodály Institute)*
19.00	Welcome Party *(Café Liberté)*

15th May, 1995

08.00 - 08.30	Opening Ceremony
08.30 - 13.00	Scientific program
13.00 - 14.00	Lunch
14.00 - 16.30	Scientific program
18.15 - 23.00	Party: *"New Tanya Csárda"*, Lajosmizse

Our guests will be provided bus transport to the Party. Departure at 17.45 from Hotel Aranyhomok and Hotel Három Gúnár.

16 th May, 1995

08.00 - 13.00	Scientific program
13.00 - 14.00	Lunch
14.00 - 17.30	Scientific program
17.30	Closing ceremony

Optional program: Museums, Exhibitions in Kecskemét

Bozsó Collection	Klapka u. 34.
Ráday Museum	Szabadság tér 7.
Katona József Museum	Bethlen krt. 1.
Kecskemét Gallery	Cifra Palota
Kodály Zoltán Institute	Kéttemplom köz
Museum of Naive Painters	Gáspár Antal u. 11.
International Glaze Museum	Bethlen krt. 16.
Szórakaténusz Museum of Toys and Games	Gáspár Antal u. 11.

Scientific Program

15th May, 1995

08.00 - 08.30 Opening ceremony

Prof. Pásztor Emil	Honorary President of the Congress
Prof. Frederich Holmes	Kansas Medical University
Kovács Á. Gábor MD	Director of County Hospital, Kecskemét
Bense Katalin MD	Local organizer
Gádoros Julia MD	Secretary of Section Psychiatry
Svékus András MD	Secretary of Section Neurology & OC

08.30 - 10.30 Pediatric malignancies

President: Kepes, John, Dobai József

Kepes, J. *(University of Kansas Medical Center)*
Meningeoma in the lateral ventricle of a teenager, with late recurrance (20 min)

Fazekas I. *(National Institute of Neurosurgery, Budapest)*
Brain tumors in infancy: behaviour in monolayer culture (10 min)

Slowik F. *(National Institute of Neurosurgery, Budapest)*
Brain tumors in infancy: morphological characteristics (10 min)

Kónya E., Fazekas I., Slowik F., Paraicz E. *(National Institute of Neurosurgery, Budapest)*
Brain tumors in infancy: clinical characteristics concerning the morphological structure.
(Follow up study) (10 min)

Velkey I., Nagy K., Dobai J. *(County Hospital, Miskolc)*
Change of frequency of pediatric brain tumors in North-East Hungary (10 min)

Klun, B. *(Department of Neurosurgery, University of Ljubljana, Ljubljana)*
Forty years experience with craniopharyngeoma (10 min)

Steno J, Bizik I., Biksadsky P., Malacek *(Department of Neurosurgery, Comenius University, Bratislava)*
Craniopharyngiomas in children and adolescents (10 min)

Morvai M. *(MRE Bethesda Children's Hospital, Budapest)*
Intracranial manifestation of neuroblastomatosis in childhood. Review of the disease a'propos one case (10 min)

Kónya Cs., Dobai J. *(County Hospital, Miskolc)*
Operated extreme large bifrontal meningeoma with infiltration of the cranial vault in an adolescent boy (10 min)

Lajgut A., Velkey I., Barla S., Lombay B. *(County Hospital, Miskolc)*
Operated malignant intraventricular ependymoma associated with tuberous sclerosis (10 min)

Tegzes A., Velkey I., Lombay B. *(County Hospital, Miskolc)*
Long-term remission of an inoperable brainstem tumor occasioning a Foville syndrome (10 min)

Discussion (20 min)

10.30 - 11.00 Free topics

Nagy A., Szabó L.T., Barsi P. *(Madarász Children's Hospital, Budapest)*
Case history of a ten-year-old boy suffering of sinus rectus thrombosis (10 min)

Steno J., Bizik I., Biksadsky P., Malacek M. *(Department of Neurosurgery, Comenius University, Bratislava)*
Cerebellar astrocytomas in children (10 min)

Szever Zs., Nagy A., Sült T., Hrabák K. *(Madarász Children's Hospital, Heim Pál Children's Hospital, Budapest)*
New approach to basilar fractures of the skull in childhood (10 min)

Bognár L. *(National Institute of Neurosurgery, Budapest)*
Management of tectal gliomas (10 min)

Discussion (10 min)

11.00 - 11.20 Coffee break

11.20 - 13.00 Epilepsy

President: György Ilona, Balogh Attila

Janszky J., Halász P., Perényi J. (National Institute of Neurology & Psychiatry, Budapest)
Causal diagnosis for progressive myoclonus epilepsy (10 min)

Payerová, J., Sykora, P., Brozmanová, M. (University Children Hospital, Dept. of Neurology, Bratislava, Slovakia)
Progressive myoclonus epilepsies: diagnosis and treatment (10 min)

György I. (Pediatric Deptm., Medical University, Debrecen)
Therapeutic results in West syndrome (10 min)

Kálmánchey R., Neuwirth M., Nagy A., Sós I., Siska É. (II. Pediatric Deptm, Semmelweis Medical University, MRE Bethesda Children's Hospital, Heim Pál Children's Hospital, National Institute of Neurology & Psychiatry, Budapest)
Epilepsy in late infantile type of neuronal ceroid lipofuscinosis (10 min)

Szabados P., Berényi M., Gisztl E., Halász P., Katona F., Kakuk E. (Pediatric Institute Szabadsághegy, National Institute of Neurology & Psychiatry, Budapest)
Alternative faces of West syndrome (10 min)

Zubiel, M., Wendorff, J., Popielarczyk, M. (Neuropediatric Dept. of Polish Mothers Memorial Hospital, Lódz, Poland)
Epilepsy in children with hemimegalencephaly (10 min)

Balogh A., Juhos V. (Szt. István Hospital, Budapest)
Diagnostical challenges of the epileptic region (10 min)

Nikl J. (County Hospital, Zalaegerszeg)
Changes of epileptic foci in children (10 min)

Discussion (20 min)

13.00 - 14.00 Lunch

14.00 - 15.50 POOH (Pediatric Oncology Outreach to Hungary) Symposium on pediatric oncology

President: Schuller Dezső, Nyáry István

Holmes F. F., Holmes G. *(University of Kansas Medical Center)*
Fifty year follow-up of childhood cancer survivors in Kansas (10 min)

Vats T. *(University of Kansas Medical Center)*
New approaches to the treatment of brain tumors in children. (10 min)

Zhao G., Boysen C. D., Brown E., Hassaenein K., Holmes F. F., Holmes G. E. *(University of Kansas Medical Center)*
Long survival and prognostic factors in childhood and adolescent cancer (10 min)

Cap J., Husaková K., Bajciava V., Oravkinova I., Sykora, P *(Department of Pediatric Oncology, University Childrens Hospital, Bratislava)*
15 years experience with the treatment of children with MB/PNET in Slovakia (15 min)

Kouteczky J. *(Department of Pediatric Oncology, Charles University, Prague)*
Treatment of pediatric brain tumors in the Czech Republic

Nicolau S. *(Institute of Oncology, Bucharest)*
Some aspects of malignancies in children, brain tumors in childhood (10 min)

Kowalczyk J.R. *(Department of Pediatric Hematology, Childrens Hospital, Lublin)*
Polish Pediatric Hematology/Oncology Group - present status and activities (15 min)

Gebauer E., Cvetkovic P. *(Institute of Child Health, School of Medicine, Novi Sad)*
Present status of pediatric oncology in Serbia (10 min)

Cepulic M. *(University Childrens Hospital, Zagreb)*
Present situation and possibilities of further development of pediatric oncology in Croatia (10 min)

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15.50 - 16.30 Tumor section in Hungarian

President: Velkey Imre, Kónya Eszter

Barla S., Velkey I., Nagy K., Dobai J. (Megyei Kórház, Miskolc)
Operált bal oldali frontális tumor (olfactorius neuroblastoma?)
(10 min)

Dobai J., Nagy G., Skapinyecz J., Papp A., Fügedi L. (Megyei Kórház, Miskolc)
Serdülőkori arterio-venosus malformatiok műtéti kezelésével nyert tapasztalataink
(10 min)

Gyorsok Zs., Simon G., Komora C. (Megyei Kórház, Székesfehérvár)
Dermoid lumbosacrale recidiv purulens meningitisek hátterében
(10 min)

Discussion (10 min)

16th May, 1995

08.00 - 10.30 Epilepsy

President: Jerney Judit, Nemes András

Kóbor J. (Pediatric Dept., Szent-Györgyi A. Medical University, Szeged)
Multiplex cerebral malformation, intracranial calcification, epilepsy (10 min)

Nemes A., Palya L., Nagy I. (County Hospital, Szolnok, National Institute of Neurosurgery, Budapest)
Simple partial seizure in infant's stroke (10 min)

Hollódy K., Dani M. (Pediatric Deptm., Medical University, Pécs)
Seizure as the presenting symptom of brain tumor in childhood
(10 min)

Kozma I., Balogh E., Kiss A. (International Pethő Institute, Budapest)
Dystonic and/or dyskinetic cerebral paresis and epilepsy (10 min)

Medveczky E., Kercsó A., Kozma I. (International Pethő Institute, Budapest)
Postictal movement in recovery cerebral paresis (10 min)

Medveczky E., Kercsó A., Balogh E. (International Pethő Institute, Budapest)
Movement disorders and epilepsy in CP (10 min)

Kaloczkay A., Halász P. (Haynal I. University of Health Sciences, Dept. of Neurology, Budapest)
Rasmussen syndrome (case report) (10 min)

Donauer N., Kassay M., Jerney J. (National Institute for Nervous & Mental Diseases, Epilepsy Center, Heim Pál Hospital and Epilepsy Center, Budapest)
Differences in the cognitive variables of sustained attention task between absence epileptic and normal children (10 min)

Sarungi E. (Dept. of Pediatric Psychiatry, Szent-Györgyi A. Medical University. Szeged)
Visual psychotherapy with an epileptic child. (Case report) (10 min)

Berényi M., Gisztl E., Halász P., Katona F., Szabados P., Kakuk E. (Pediatric Institute Szabadsághegy, Haynal I. University of Health Sciences, Dept. of Neurology, Budapest)
New drugs and old results in the treatment of intractable epilepsy
(10 min)

Szelestei D., Kálmánchey R., Liptai Z., Gaszner A. (II. Pediatric Dept., Semmelweis Medical University, Budapest)
Sleep-deprivation EEG recording in the decision of discontinuing antiepileptic therapy in childhood epilepsy (10 min)

Gaszner A., Kálmánchey R., Liptai Z., Nagy É. (II. Pediatric Dept., Semmelweis Medical University, Budapest)
Effectiveness of low dosis ACTH therapy in West syndrome (10 min)

Discussion (30 min)

10.30 - 11.00 Coffee break

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11.00 - 13.00 Epilepsy

President: Ebner, Alois; Halász Péter

Ebner, A. (Epilepsie-Zentrum Bethel, Germany)
Methods of presurgical evaluation in medically resistant epileptic patients (30 min)

Halász P., Vajda J., Sólyom A., Kaloczkay A. (Haynal I. University of Health Sciences, Dept. of Neurology, National Institute of Neurosurgery, Budapest)
Diagnostic possibilities and strategies for presurgical evaluation in our disposal (20 min)

Hajnsek, S., Pirker, H. (Dept. of Neurology, Epilepsy Center, Zagreb, Croatia)
Needs and possibilities for surgical treatment of epilepsy in Croatia (10 min)

Csoszánszki N., Kálmánchey R.I, Váraljai Gy., Vajda J. (II. Pediatric Dept., Semmelweis Medical University, National Institute on Neurology & Psychiatry, National Institute of Neurosurgery, Budapest)
Epilepsy in congenital bilateral perisylvian syndrome (case report) (10 min)

Liptai Z., Kálmánchey R., Almásy Zs., Gaszner A. (II. Pediatric Dept., Semmelweis Medical University, Budapest)
Benign neonatal familial convulsions (10 min)

Katona F., Berényi M., Gisztl E., Halász P., Szabados P., Kakuk E. (Pediatric Institute Szabadsághegy, Haynal I. University of Health Sciences, Budapest)
Neurohabilitation handicapped by early intractable epilepsy (15 min)

Discussion (25 min)

13.00 - 14.00 Lunch

14.00 - 14.50 Common section with Pediatric Psychiatry

President: Gádoros Júlia

Lask, Brian (London)
Psychological aspects of chronic illness and the child. Illness and the family (50 min)

14.50 - 15.00 Coffee Break

15.00 - 15.40 Epilepsy

President: Rajna Péter, Berényi Mariann

Fábián M., Bártfay R., Bártfai E., Rajna P. (A. Kenessey Hospital, Balassagyarmat, Dept. Psychiatry and Psychotherapy, Semmelweis Medical University, Budapest, National Institute of Meteorology, Budapest)
Possible connection between epileptic seizures and biometeorological changes. A retrospective study (10 min)

Gisztl E., Berényi M., Halász P., Katona F., Sós I., Szabados P. (Pediatric Institute Szabadsághegy, Haynal I. University of Health Sciences, Dept. of Neurology, Budapest)
Mikrocephaly and epilepsy (10 min)

Szever Zs., Bogárdi M., Lácza E., Csepella Z. (Madarász Pediatric Hospital, Budapest, Heim Pál Pediatric Hospital, Budapest)
The efficacy of Sabril (Vigabatrin) in partial seizures (10 min)

Buraga, I., Cheroiu, I. (Universitary Hospital of Bucharest, Roumanie)
Valproic acid monotherapy in newly diagnosed epileptic pediatric patients (10 min)

Discussion (10 min)

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15.50 - 17.00 Epilepsy - section in Hungarian

President: Neuwirth Magda, Kassay Mária

Neuwirth M., Sólyom A. (MRE Bethesda Gyermekkórháza, Budapest)
Az infantilis spasmus kezeléséről, saját tapasztalat alapján (10 min)

Paraicz É., Neuwirth M., Kassay M., Jerney J. (MRE Bethesda Gyermekkórháza, Heim Pál Kórház Epilepszia Centrum, Budapest)
Tapasztalataink az asztatikus, myoclonusos epilepsziában szenvedő gyermekek kezelésében (10 min)

Kampós K., Katona Á. (Jávorszky Kórház, Vác)
Serdülőkor és epilepszia - 20 év gondozás tapasztalatai (10 min)

Altmann A., Jerney J., Kassay M., Csepella Z. (Heim Pál Kórház Epilepszia Centrum, Budapest)
Brain Quick EEG monitorizálással szerzett tapasztalataink (10 min)

Kassay M., Neuwirth M., Jerney J., (Heim Pál Kórház Epilepszia Centrum és MRE Bethesda Gyermekkórháza, Budapest)
Lamictallal szerzett tapasztalataink gyermekkori epilepsziák kezelésében (10 min)

Kollár K., Jelenik Zs. (Mentálhigiénés Gondozó, Dunaújváros, Szt. László Kórház, Budapest)
AIDS betegség neurológiai vonatkozásai (10 min)

Discussion (10 min)

17.00 - 17.30 Coffee break

Poster section

Bobest M., Ruzsa A., Masáth P., Szalók I. *(Markusovszky Hospital, Szombathely)*
A Szombathelyi Gyermekonkológiai Centrum központi idegrendszeri tumoros beteganyaga az elmúlt 10 évben (1985 - 1994)

Szabó J., Bobest M., Masáth P., Szalók I. *(Markusovszky Hospital, Szombathely)*
Occlusiv hydrocephalus halmozott, ritka szövődményei

Kopniczky Zs. *(Szent-Györgyi A. OTE, Szeged, Idegsebészeti Klinika)*
Dysembrioplasticus neuroepithelialis tumor: sebészileg gyógyítható epileptogén laesio

Mikos B., Vass Zs. *(Megyei Kórház, Miskolc)*
A gyermekkori hátsó skálai tumorok műtéti anaesthesiájának speciális szempontjai

Kasza E. *(Szent-Györgyi A. OTE Gyermekklinika, Gyermekpszichiátriai Részleg, Szeged)*
Életesemények, szorongás és depresszió epilepsziás gyermekekben

Kollár K. *(Mentálhigiénés gondozó, Dunaújváros)*
Komplex számítógépes gondozói programmal szerzett tapasztalataink

17.30 Closing ceremony

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Section II

Gyermekpszichiátriai szekció programja

1995. május 15.

08.00 - 08.30 Megnyitó ünnepség

08.30 - 09.00 Liaison Psychiatry

Elnök: Fedor István

Prof. Perry Jones, *(Glasgow)*
Psychiatric care of adolescents with cancer

09.00 - 11.00 Farmakoterápia a gyermekpszichiátriában

Elnök: Oláh Róza

Bánk Zsuzsa, Oláh Róza:
Gyógyszeres terápiánk változása

Vereby Beáta, Storcz Judit:
Ritalinnal vagy anélkül?

Besnyő Márta
"Rosszcsont?" - Ritalinnal kapcsolatos tapasztalataink és dilemmáink

Radics Edit:
Néhány konkrét eset kapcsán szerzett tapasztalat a Prozac gyermekeknél történő alkalmazhatóságára

Ács Katalin, Balázs Mária, Lődy Annamária, Trém Ildikó
Anafranil kezeléssel szerzett tapasztalataink gyermek- és serdülőkorban

11.00 - 11.20 Kávészünet

11.20 - 12.50 Gyermeki fejlődés kérdései

Elnök: Storcz Judit

Vajda Zsuzsa:
Koraszülött gyermekek iskolai teljesítményének utóvizsgálata 14 éves korban

Sebestyén Szilvia, Riegler Mária
Nyelvi fejlődési zavar diagnosztikája

Sebestyén Szilvia, Szvatkó Anna:
Ayres szenzomotoros integrációs fejlesztő program

12.50 - 14.00 Ebédszünet

14.00 - 16.30 Adolescens problémák

Elnök: Csik Vera

Fedor István, Orosz Márta
Szorongás és depresszió epidemiologiai vizsgálata serdülő populációban

Bolyós Csilla, Geiszt Tamás
Krónikus kényszerbeteg serdülők gondolkodászavarának vizsgálata

Csorba János, Farkas V., Mihadak K.:
Diszfunkcionális attitüd és depresszió adolescens migrén betegeknél

Horváth Marianna:
Öngyilkosságot elkövetett serdülők disszociális élményei

Csősz László:
A gyermek-serdülő pszichiátria hazai helyzete egy súlyos endogén depressziós beteg kezelésének tükrében

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1995. május 16.

08.30 - 10.30 Kapcsolati pszichiátria II

Elnök: Vetró Ágnes

Varró Gábor
Kapcsolati pszichiátria gyermekkórházban. Az első évek tapasztalatai

Kaczwinszky Emilia, Román Ferenc
Halálra várva? (Gondolatok egy Münchhausen syndoma by proxy kapcsán)

Osváth Viola, Fedor István, Jenei Zsuzsanna
Családszerkezeti vizsgálat gyermekkori hyperkinetikus figyelemzavar betegségben

Csősz László
Osztályszervezési problémák a szolnoki gyermek- és serdülőpszichiátrián

Deli Edit, Csősz László
Gyermek- és serdülőpszichiátriai fekvőbeteg ellátás és teljesítmény- arányos finanszírozás

10.30 - 11.00 Kávészünet

11.00 - 13.00 Kapcsolai pszichiátria III.

Elnök: Csorba János

Csík Vera, Fedor István, Barton Joanna:
Posztttraumás stressz betegség szűrővizsgálatok a nagyatádi menekülttábor gyermekei között
Gyurcsó Mária, Radó Emilia:
Ami az újságcikkekből kimaradt

Hasuly Rózsa:
Árnyékban. Miért? Gyöngyös és környéke cigány kisebbségi helyzete a gyermekpszichiáter szemszögéből

Palaczky Mária:
A gyermekbántalmazás szemlélet, mint Ariadne fonala, avagy barangolások a pszichiátriai irányzatok útvesztőiben

Révész György, Palaczky Mária:
Óvjuk meg a gyermekeket a bántalmazástól - egy komplex prevenciós program tapasztalatai

13.00 - 14.00 Ebédszünet

14.00 - 14.50 Plenáris ülés (Kongresszusi Terem)

Elnök: Gádoros Júlia

Prof. Brian Lask (London)
Psychological aspects of chronic illness and the child. Illness and the family

14.50 - 15.00 Kávészünet

15.00 - 17.00 "Merre tovább, gyermekpszichiátria?"

Kerekasztal a Társaság Gyermek- és Ifjúságpszichiátriai Szekciójának vezetősége és tagsága részvételével

17.00 - 17.30 Kávészünet

17.30 Zárszó

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Appendix Me. 15

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Challenges and Opportunities in Pediatric Oncology

October 6-9, 1996

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A New York Academy of Sciences Conference

Jointly sponsored by the Pediatric Oncology Outreach to Hungary program of the University of Kansas Medical Center, Kansas City, Kansas through a grant from the United States Agency for International Development

Final Program

Conference Site

The Ramada Grand Hotel (RGH) and
Thermal Hotel Margitsziget (THM)
Budapest, Hungary
Tel. (36-1)-3111000
Fax RGH (36-1)-1533029
Fax THM (36-1)-2694587

Conference Registration Hours

The Conference Registration Desk will be open on Sunday, October 6 from 12:00 Noon to 3:00 PM in the corridor outside of Conference Rooms I and II in the Thermal Hotel. The Registration Desk will re-open on Monday, October 7 at 7:15 AM and will remain open for the duration of the conference.

Location of Events

The Panel Discussion and Reception on Sunday, October 6, 4:30 PM to 7:30 PM, will be held at the Museum of Fine Arts at Heroes Square. Round-trip transportation will be provided for conference participants. Buses will depart from the Thermal Hotel at 4:15 PM.

Scientific Sessions, Monday, October 7 to Wednesday, October 9, will be held in Conference Rooms I and II at the Thermal Hotel. Poster Presentations will be on display throughout the meeting in the corridor outside of the Conference Rooms.

Conference Luncheons and Banquets will be held in the Platán Restaurant at the Thermal Hotel.

Sunday
October 6, 1996

12:00 Noon-3:00 PM **Registration**
Thermal Hotel—Conference Rooms I and II

4:30-7:30 PM **Panel Discussion and Reception**
Museum of Fine Arts (At Heroes Square)

Monday
October 7, 1996

Scientific Sessions will be held in Conference Rooms I and II at the Thermal Hotel.

7:15 AM-6:00 PM **Registration**

8:30-9:00 AM **Welcome and Introductory Remarks**

Árpád Göncz, President of Hungary
Donald M. Blinken, United States Ambassador to Hungary
György Szabò, M.D., Minister of Welfare, Hungary
Sándor Eckhardt, M.D., Ph.D., D.Sc., Immediate Past President, International Union Against Cancer (UICC)
Henry M. Greenberg, M.D., Chairman of the Board, New York Academy of Sciences
László Romics, M.D., Ph.D., D.Sc., Rector, Semmelweis University Medical School
Rudolf de Châtel, M.D., Ph.D., D.Sc., Dean Semmelweis University Medical School
Frederick F. Holmes, M.D., Conference Chair

9:00-12:25 PM **Session I**
Molecular Genetics and Transplantation

Session Chair:

György Fekete, M.D., Ph.D., D.Sc.
2nd Department of Pediatrics
Semmelweis University Medical School
Budapest, Hungary

Each paper includes 25 minutes for presentation followed by 10 minutes for discussion.

9:00 **1. Molecular Genetic Basis of Cancer Development**

László Kopper, , M.D., Ph.D., D.Sc.
1st Institute of Pathology and Experimental Cancer Research
Semmelweis University Medical School
Budapest, Hungary

9:35 **2. The Diagnostic and Prognostic Significance of Chromosomal Abnormalities in Acute Lymphocytic Leukemia in Children**

Éva Oláh, M.D., Ph.D., D.Sc.
Department of Pediatrics
University Medical School
Debrecen, Hungary

10:10 **3. Apoptosis and Acute Lymphocytic Leukemia in Children**

Dezső Schuler, M.D., Ph.D., D.Sc., F.R.C.P.
Conference Chair
(Co-author: *Béla Szende, M.D., Ph.D., D.Sc.)*

10:45-11:15 AM **Intermission**

11:15 **4. The Present Role of Bone Marrow and Stem Cell Transplantation in the Therapy in Leukemic Children**

Univ.Prof.Dr.med. Helmut Gadner
St. Anna Children's Hospital
Vienna, Austria

11:50 **5. Minimal Residual Disease in Leukemia in Children**

Bernhardt Kornhuber, M.D.
Department of Pediatric Hematology and Oncology
Johann Wolfgang Goethe-University
Frankfurt, Germany

12:25-2:00 PM **Conference Luncheon**
Platán Restaurant—Thermal Hotel

2:00-6:00 PM **Session II**
Clinical Application of Basic Science Knowledge

Session Chair:

Dezső Schuler, M.D., Ph.D., D.Sc., F.R.C.P.
Conference Chair

2:00 **6. Chemotherapy of Acute Lymphocytic Leukemia: The American Experience**

David Poplack, M.D.
Department of Pediatrics
Section of Hematology Oncology
Baylor College of Medicine
Houston, Texas

2:35 **7. The Development of Chemotherapy in Acute Lymphocytic Leukemia in Children**

Hansjörg Riehm, M.D.
Department of Pediatrics
Hannover Medical School
Hannover, Germany

3:10 **8. Correlation Between Morphologic and Non-Morphologic Prognostic Markers in Neuroblastomas**

Vijay V. Joshi, M.D.
Department of Pathology and Laboratory Medicine
East Carolina University School of Medicine
Greenville, North Carolina

3:45-4:15 PM **Intermission**

4:15 **9. Chemotherapy of Acute Myelocytic Leukemia in Children**

Sverre O. Lie, M.D.
Department of Pediatrics
National Hospital of Norway
Oslo, Norway

4:50 **10. Epidemiology and Treatment of Non-Hodgkins Lymphoma in Children**

Ian Magrath, M.D.
Lymphoma Biology Section
National Cancer Institute
National Institutes of Health
Bethesda, Maryland

5:25 **11. The Prognostic Significance of Biological Markers in Leukemia**

Jaques Otten, M.D.
Department of Pediatric Oncology
AZ-Kinderen VUB
Brussels, Belgium

6:00 PM **Adjourn**

Monday Evening
October 7, 1996

7:00-10:00 PM **Conference Banquet Honoring John J. Kepes, M.D.**
Platán Restaurant—Thermal Hotel

Speaker: *John J. Kepes, M.D.*
(Co-author: *Felicia Slowik, M.D.)*

"A. Lindau's Cerebellar Hemangioblastoma 70 Years Later: Some Pediatric Aspects"

Tuesday
October 8, 1996

8:00 AM-6:00 PM **Registration**

8:45-12:10 PM **Session III**
Gliomas in Infants and Children

Session Chair:

István Nyáry, M.D., Ph.D.
Conference Chair

Each paper includes 25 minutes for presentation followed by 10 minutes for discussion.

8:45 **12. Immunobiology of Gliomas: New Perspectives for Therapy**

Pierre-Yves Dietrich, M.D.
Division of Oncology, Tumor Immunology
Geneva Hospital
Geneva, Switzerland

9:20 **13. Molecular Biology of Central Nervous System Tumors: Craniopharyngiomas, Pituitary Adenomar and Meningiomas**

Rudolf Fahlbusch, M.D.
Department of Neurosurgery
University of Erlangen-Nürnberg
Erlangen, Germany

9:55 **14. Supra and Infratentorial Gliomas in Childhood**

Derek A. Bruce, M.D.
Department of Pediatric Neurosurgery
Children's Medical Center
Dallas, Texas

10:30-11:00 AM **Intermission**

11:00 **15. Plexus Papillomas**

Christian Saint-Rose, M.D.
Department of Pediatric Neurosurgery
Necker Hospital for Sick Children
Paris, France

11:35 **16. Surgery of Brain Stem Tumors**

István Nyáry, M.D., Ph.D.
Conference Chair

12:10 -2:00 PM **Conference Luncheon**
Platán Restaurant—Thermal Hotel

2:00-6:00 PM **Session IV**
Other Tumors of the Central Nervous System

Session Chair:

John J. Kepes, M.D.
Conference Chair

2:00 **17. Brain Tumors During the First Year of Life**

László Bognár, M.D.
Department of Pediatric Neurosurgery
National Institute of Neurosurgery
Budapest, Hungary

2:35 **18. Ependymomas**

Concezio Di Rocco, M.D.
Department of Neurosurgery
Catholic University Medical School
Rome, Italy

3:10 **19. Craniopharyngiomas**

János Vajda, M.D.
Department of Neurosurgery
National Institute of Neurosurgery
Budapest, Hungary

3:45-4:15 PM **Intermission**

4:15 **20. Adjuvant Chemotherapy of Pediatric Brain Tumors**

Tribhawan S. Vats, M.D.
Conference Chair

4:50 **21. Intraventricular Tumors in Childhood**

Claude Lapras, M.D.
Hospital of Neurology
Lyon, France

5:25 **22. Challenges in the Management of Bone Tumors**

Alan W. Craft, M.D., F.R.C.P.
Department of Child Health
Royal Victoria Infirmary
Newcastle Upon Tyne, United Kingdom

6:00 **Adjourn**

7:00-9:00 PM **Conference Banquet**
Platán Restaurant—Thermal Hotel

Wednesday
October 9, 1996

8:00 AM-5:30 PM **Registration**

8:45-12:25 PM **Session V**
Long-Term Survival, Supportive Care and Ethical Issues

Session Chair:

Frederick F. Holmes, M.D.
Conference Chair

Each paper includes 25 minutes for presentation followed by 10 minutes for discussion.*

8:45 **23. Long-Term Survival in Childhood and Adolescent Cancer—U.S.A.**

Grace E. Holmes, M.D.
Department of Pediatrics and Preventive Medicine
University of Kansas Medical Center
Kansas City, Kansas

9:20 **24. Quality Assurance of Care in Chemotherapy**

Sándor Eckhardt, M.D., Ph.D., D.Sc.
National Institute of Oncology
Budapest, Hungary

9:55 **25. Ethical Issues in Pediatric Cancer**

Josef Koutecký, M.D., D.Sc.
Department of Pediatric Oncology
2nd Medical Faculty
Charles University
Prague, Czech Republic

10:45-11:15 AM **Intermission**

*Paper number 25 includes 40 minutes for presentation followed by 10 minutes for discussion.

11:15 **26. The Problem of Pediatric Malignancies in the Developing World**

Hans Peter Wagner, M.D.
Swiss Institute for Applied Cancer Research (SIAK)
Bern, Switzerland

11:50 **27. Nutrition and Pediatric Cancer**

Hedvig Bodánszky, M.D., Ph.D.
2nd Department of Pediatrics
Semmelweis University Medical School
Budapest, Hungary

12:25-2:00 PM **Conference Luncheon**
Platán Restaurant—Thermal Hotel

2:00-5:25 PM **Session VI**
Consequences of Treatment and Screening

Session Chair:

Tribhawan S. Vats, M.D.
Conference Chair

2:00 **28. Pediatric Cancer and Psychosocial Problems**

Giuseppe Masera, M.D.
Department of Pediatric Hematology
San Gerardo Hospital
University of Milan
Monza, Italy

2:35 **29. Cardiotoxicity of Anthracyclines and its Prevention**

Martin G. Mott, D.Sc., M.B., Ch.B., F.R.C.P., D.C.H.
Department of Child Health
Royal Hospital for Sick Children
University of Bristol
Bristol, United Kingdom

3:10 **30. The Role of Clinical Pharmacological Studies in the Development of New Treatment Strategies**

Joseph D. Borsi, M.D., Ph.D., D.Sc.
2nd Department of Pediatrics
Semmelweis University Medical School
Budapest, Hungary

3:45-4:15 PM **Intermission**

4:15 **31. Emesis Control in Children with Cancer**

Csilla Csáki, M.D.
2nd Department of Pediatrics
Semmelweis University Medical School
Budapest, Hungary

4:50 **32. The Role of Cytokines and Supportive Therapy in Pediatric Malignancies**

Thomas Ferencz, M.D.
2nd Department of Pediatrics
Semmelweis University Medical School
Budapest, Hungary

5:25 **Farewell and Adjourn**