already made the transition to every-3-week dosing. For example, darbepoetin alfa can be administered on the same day as chemotherapy in patients who are receiving chemotherapy every 3 weeks. This has resulted in fewer missed doses of darbepoetin alfa, fewer injections, and fewer visits to the clinic for the patient.

JHASiN: Is an increased dosing regimen under investigation for epoetin alfa? To date, what results have the data yielded?

Ms Keegan: Yes, researchers are investigating the effects of increased doses of epoetin alfa. A recent randomized, open-label, 13-week study compared 2 dosing regimens of epoetin alfa (80 000 U every 2 weeks vs 40 000 U weekly) in patients with CIA. The study included patients who had noneomyeloid malignancies and a baseline Hgb value of less than 11g/dL. Data demonstrated that both dosing regimens of epoetin alfa were effective for treating CIA; comparable increases in Hgb levels, decreases in transfusion rates, and similar safety outcomes were observed in patients between the 2 treatment arms.2

JHASiN: What clinical practice guidelines would you implement into a neutropenic risk assessment tool for patients undergoing myelosuppressive chemotherapy? How does implementation of these guidelines affect patient outcomes?

Ms Keegan: Our clinic has implemented a neutropenic risk assessment tool that is consistent with the evidence-based guidelines of the National Comprehensive Cancer Network (NCCN). Within our clinic, the implementation of this risk assessment tool has resulted in improved patient outcomes: fewer incidences of neutropenia have occurred, the number of hospitalizations for febrile neutropenia (FN) have been significantly reduced—from 9.7% to 2.1% (P = .003)—and the total number of hospital days has decreased from 117 days to 24 days. Additionally, and very importantly, patients have been able to continue with their planned chemotherapy treatment and dosing schedules without delay or interruption.3

JHASiN: How feasible is it to implement a neutropenic risk assessment tool into clinical practice? What can
chemotherapy with stem cell transplantation (SCT)?

Ms Keegan: Patients who receive high-dose chemotherapy with SCT are at high risk for developing mucositis. Mucositis can prevent adequate oral intake of food and fluids, which makes patients vulnerable to poor nutrition and dehydration. Patients suffering from mucositis often require supportive care, including total parenteral nutrition, intravenous (IV) fluids; mucositis itself also increases the patient’s vulnerability to infection and bacteremia. Mucositis is very painful and often requires IV narcotics for optimal pain control. The prevention of mucositis and a decrease in its severity when it occurs are of the utmost importance to improve patient outcomes and quality of life. Oncology NPs and PAs must be aware of and advocate for the use of supportive care to meet the needs of their patients with or at-risk for chemotherapy-induced complications. Although the mechanisms causing mucositis are not fully understood, data suggest that palifermin, a keratinocyte growth factor, may decrease the length of hospitalization as a result of mucositis and the severity of the condition in patients undergoing hematopoietic stem cell transplant. In a retrospective chart review, patients who received palifermin experienced decreased incidence and duration in mucositis and had shorter hospital stays and earlier engraftment than patients who did not receive the agent.4

REFERENCES