

Tough Courage: Oncology Nursing Forum Addresses Childhood Cancer Then and Now

Cancer is a devastating diagnosis for anyone, but none more so than for children and their parents—so many questions to be asked, so much information to sift through and absorb, and so many difficult decisions to be made. It is no wonder that a diagnosis of childhood cancer is often met with fear, anger, guilt, and feelings of being overwhelmed, yet also a determined resilience on the part of families to do whatever it takes to help their child get well again (Rishel, 2010).

Childhood cancer is not very common in the United States, making up fewer than 1% of all annual cancer diagnoses. In 2012, approximately 12,060 children younger than 14 years were diagnosed with cancer (Siegel, Naishadham, & Jemal, 2012). For the children and their families, however, the incidence of disease is not their primary concern. Far more important is the fear of what the future holds as well as how they will navigate the journey that has been unwillingly forced on them.

Sadly, the rates of cancer occurrence in children have been rising ever so slightly since the 1970s. However, because of major treatment advances during the same time period, 83% of children with cancer will experience a survival rate of five years or more. This is significant as the five-year survival rate for childhood cancer in the 1970s was 58% (Siegel et al., 2012).

In the 1970s

One of the earliest articles published by *Oncology Nursing Forum* (ONF) on childhood cancer was Bakke's (1978) informational article focused on nursing considerations in caring for adolescents with osteosarcoma, specifically teenagers whose treatment plan included amputation of the affected limb. Several key considerations for pediatric oncology nurses were discussed, most importantly that when caring for children (regardless of age), nurses must thoroughly assess each child's history of growth and development, any current or previous behavior issues, how the child manages or copes with stress, and any other external influences (e.g., family disruption) that could impact the child's ability to manage the course of treatment and recovery. Because osteosarcoma is primarily a disease of adolescents, Bakke (1978) emphasized understanding the "current

social and cultural demands on teenagers, the importance they place on peer acceptance and the changes and stresses faced by the family" (p. 14). Nurses caring for these patients were cautioned about the need to continually reassess the family's comprehension and understanding of what was happening to their child and, concomitantly to the family itself; the amount and type of information that each family member not only wanted but was able to handle at any given point in time; and family patterns of communication (Bakke, 1978). Family members also needed to be heard and assessed by the nurse. Having an opportunity to safely vent potentially conflicting emotions was reported as being particularly important in establishing the ability of the parents to provide meaningful support to their adolescent child. Because of the very aggressive treatment regimen for most patients with osteosarcoma at that time (including limb amputation and extensive chemotherapy), nurses were implored to be sensitive to the adolescents' developmental needs and make "appropriate and perceptive interventions" (Bakke, 1978, p. 14) when working with patients and families.

Today, osteosarcoma remains a disease primarily of adolescence that is believed to be related to rapid bone growth typically found during this developmental period. Treatment for osteosarcoma generally begins with chemotherapy in an effort to shrink the cancerous tumor. The duration of treatment is dependent on tumor size, whether any malignant cells have spread, and how well the tumor responds to treatment. Once the course of chemotherapy is finished, surgeons will operate to remove any remaining tumor and surrounding bone, oftentimes sparing the child's limb from amputation. Any bone that is missing can be replaced with artificial bone at the time of surgery. If any microscopic cancer cells remain following surgery, they can be treated with additional chemotherapy (Ta, Dass, Choong, & Dunstan, 2009).

Although the current treatment of osteosarcoma is somewhat less invasive than it was in the 1970s, the nursing assessment and management of the patient and family remain almost the same. The early emphasis by Bakke (1978) on the need to complete a holistic assessment of the child and family was right on point. A thorough assessment of the child's growth and development pattern; behavioral responses to things such as stress and pain; the pattern of family life, including their communication styles; and other key concerns is vitally important to the foundation of providing high-quality nursing care. Pediatric oncology nurses have many