



Operational Aspects of the Surgical Oncology Nurse Practitioner

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Linda Sesa, MSN, RNC

Nurse Practitioner

Division of Surgical Oncology

Cancer Institute of New Jersey

New Brunswick, New Jersey

Linda Sesa, MSN, RNC, discusses, via a case study, operational aspects of the APN in the setting of surgical oncology at CINJ. The following summarizes Ms. Sesa's presentation.

Protocol

- The surgical oncology nurse practitioner (NP) obtains a complete patient history and physical exam. During this time, the NP focuses on the anticipatory needs of the patient based on specialty knowledge required by a surgical oncology NP.
- Implementing the plan of care, managing postoperative complications, referrals and follow-ups will be discussed while collaboration occurs between the NP, the surgeon, and the entire oncology health care team.

History

- Mrs. D is a 34-year-old woman who presents to the clinic with a left breast mass discovered one week earlier with an abnormal mammogram and ultrasound. The patient has a history of mitral valve prolapse, a previous benign breast biopsy, and a strong family history of breast cancer.
- Mitral valve prolapse is a common cardiac condition in younger women and is probably a benign finding. However, the NP anticipates that a cardiology consult would be necessary should this patient require surgery. Because the patient also has a strong family history of breast cancer, the NP foresees the need to refer the patient to the high-risk program at CINJ.
- The patient is currently on oral contraceptives. A breast cancer diagnosis requires that she stop taking any estrogen-containing medication. The rationale for this would be explained to the patient by the NP.

Physical Examination

- No significant cardiac, respiratory, musculoskeletal or constitutional symptoms. Menarche at the age of 12; menses normal, gravida 2, para 2, age of first live birth 25; she used oral contraceptives for 6 years.

- Examination reveals a 1 cm palpable, hard mobile mass of the left axilla and a 2 cm hard mobile mass in the left breast, suspicious for malignancy. The patient's history of mitral valve prolapse is confirmed. Any positive findings found on the initial exam are discussed and confirmed with the surgeon.

Radiological Data

- Bilateral mammogram and left breast ultrasound reveal a 2 cm spiculated mass in the left breast suspicious for malignancy.
- Mammograms are discussed and reviewed by the NP and the surgeon.

Impression and plan

- This is a 34-year-old woman with probable adenocarcinoma.
- A fine needle aspiration of the breast mass with immediate on-site assay is performed by either the surgical oncology NP or the surgeon.
- Cytology reveals adenocarcinoma. The surgeon and NP collaboratively develop a plan of care based on either standard of care or research protocols. A 30- to 40-minute consultation then occurs between the surgeon and the patient. The NP may be present for this visit.
- Pre- and postoperative patient education is done by the surgical oncology NP. All of the patient's questions and concerns are addressed. The patient is also referred to the on-site, patient-friendly learning center for literature and information on her disease and its treatment.
- Recognizing that a patient, newly diagnosed with a breast cancer may be highly anxious and overwhelmed with information, CINJ offers a social worker consult. This can be done at the time of the patient's initial visit, or at a later date, depending on patient preferences.
- Patients are also told that they may call their surgical oncology NP that evening to ask questions, reiterate or reinforce any part of their plan of care.
- The patient in this case requires staging studies and preadmission testing, and these tests are ordered and interpreted by the surgical oncology NP. The NP consults with the surgeon if there are any concerns regarding test results and also orders and interprets any additional tests as needed.
- Test results are discussed with the patient, usually over the telephone.
- If all studies are within normal limits, the patient is scheduled for surgery. The patient in this case is also referred for a cardiology consult and surgical clearance, and a high-risk referral is implemented.

Postoperative Follow-Up

- Pathology reveals lumpectomy with infiltrating ductal carcinoma, 2.2 cm, ER+ PR+ Her2/Neu-positive with a tumor extending to < 1 mm of the superior margin. Two out of 14 lymph nodes are positive.

- The surgical oncology NP discusses the patient's pathology report with her via telephone. Any uncertainties regarding the pathology are first discussed with the surgeon. In this case, the patient has close margins and the possibility of a reexcision will be discussed.
- The patient is then scheduled for a post-op appointment and the drain is removed by the NP or surgeon. At this visit, the surgeon will again review the pathology.
- Occasionally, patients will call with issues, such as a seroma or an infection, which need to be addressed in person by the NP or surgeon. These phone calls are directed to the NP through the triage nursing help line. As necessary, the patient comes in to see the surgical oncology NP. In some cases, a referral is made to a visiting nurse agency, initiated under the care of the physician for daily at-home wound care visits.
- At this point, the patient is ready to move on to medical oncology, and the referral is made by the surgical oncology NP. Radiation oncology referrals are also initiated at the indicated time.
- In follow-up, surgical oncology NPs see patients every 6 months unless a problem occurs. At these visits, a general health assessment is performed, focusing on signs of local or regional recurrence. This assessment is performed by either the NP or the surgeon, with confirmation of any positive finding by the surgeon.
- At 2 years post-treatment (excluding treatment with tamoxifen), the patient is referred to the Survivors Clinic, where APNs focus on long-term issues, such as ongoing medical care and symptom management. In addition, health maintenance appointments and referrals are initiated if needed, such as referrals for routine gynecological screening, annual mammograms, or perhaps a GI consult for a routine screening colonoscopy. Should a problem occur that is beyond the scope of the NP, the patient would then be referred back to either the medical oncologist or surgeon.