St James’s Hospital

Haematology Oncology

Telephone Triage Guidelines

Amy Nolan, Norma Daly, Emma Rowan

Haematology Oncology Day Ward, St James’s Hospital, James Street, Dublin 8.
# Contents

**Introduction** ................................................................................................................................. 3  
**Aims** .............................................................................................................................................. 3  
**Scope** ............................................................................................................................................ 3  
**Infection** .......................................................................................................................................... 4  
**CVAD** ............................................................................................................................................. 6  
**Nausea** ............................................................................................................................................ 7  
**Vomiting** .......................................................................................................................................... 9  
**Diarrhoea** ....................................................................................................................................... 11  
**Constipation** ................................................................................................................................. 16  
**Mucositis** ...................................................................................................................................... 18  
**Breathlessness** ............................................................................................................................... 20  
**Fatigue** .......................................................................................................................................... 23  
**Skin Rashes** .................................................................................................................................. 25  
**Ascities** .......................................................................................................................................... 29  
**Mood Alteration** ............................................................................................................................ 31  
**Pain** ................................................................................................................................................ 33  
**Ambulatory Pump** ......................................................................................................................... 35  
**Peripheral Neuropathy** .................................................................................................................. 36  
**References** ..................................................................................................................................... 37  
**Appendix 1. Oncology Telephone Triage Form** ............................................................................ 38  
**Appendix 2. Haematology Telephone Triage Form** ...................................................................... 40
INTRODUCTION

The Haematology / Oncology services in St. James’s Hospital provides over 25,000 episodes of care annually, mostly involving the administration of cytotoxic chemotherapy, which can have life threatening side effects. Telephone triage provides 24 hour assessment and advice for patients experiencing the effects of disease or treatment. Timely, effective intervention in managing these side effects can be life-saving.

"Triage" comes from the French verb "trier" meaning "to separate, sort, sift, select, or choose".

Within the haematology and oncology services, triage refers to the assessment of the expected and unexpected effects of therapy in order to prioritise and expedite the most appropriate care for patients.

Within the HOPe Directorate, telephone triage is a dedicated service provided by senior oncology and haematology nurses which ensures patient issues are thoroughly assessed and dealt with in an appropriate and timely manner. During core operational hours, the telephone triage service is provided by the Haematology Oncology Day Ward team and after 6pm, at weekends and on public holidays, by the nursing teams of Denis Burkitt (Haematology) and Walter Stevenson (Oncology) wards.

The following guidelines are used in conjunction with a standardised assessment tool to assess the patients’ problems. Details of all interactions are recorded on the Electronic Patient Record (EPR).

AIMS

The aims of these guidelines are:
  - To guide clinical staff in the assessment and management of patients
  - To guide clinical staff providing advice for patients, carers and/or families.
  - To standardize the advice given to patients.
  - To assist the decision making process.
  - To promote appropriate use of services and resources and support the reduction of avoidable hospitalizations.
  - The guidelines should be used in conjunction with the telephone triage form(s) (Appendix 1 & 2).

SCOPE

These guidelines apply to all patients experiencing problems following treatment, within the HOPe Directorate.
**Infection**

**Initial Assessment Questions**

1. What is the patient’s temperature?
2. How long has the patient had a temperature?
3. Has the patient any shivers or shaking?
4. How long have they had shivers or shaking?
5. When did the patient receive their last chemotherapy treatment?
6. Does the patient have a central venous catheter?
7. Does the patient also have any other symptoms?
8. Is the patient conscious and responsive?
9. Is this patient post transplant? If yes follow the algorithm in Figure 1.

**Figure 1. Algorithm for post transplant patient**

```
<table>
<thead>
<tr>
<th>&lt; 100 days post transplant</th>
<th>&gt; 100 days post transplant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attend HODC/DBW immediately</td>
<td>Are they on Immunosuppression:</td>
</tr>
<tr>
<td></td>
<td>- Cellcept</td>
</tr>
<tr>
<td></td>
<td>- Tacrolimus/Cyclosporin</td>
</tr>
<tr>
<td></td>
<td>- Photopheresis</td>
</tr>
<tr>
<td></td>
<td>- Steroids</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Attend HODC/DBW</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Discuss with Doctor/CNS</td>
</tr>
</tbody>
</table>
```
ACTION: ANY GRADE OF INFECTION (NEUTROPENIA)
Patients must be assessed immediately and urgently by clinical staff with experience of handling neutropenic patients.

**SIGNS OF INFECTION IN NEUTROPENIC PATIENTS**

May include any of the following

- Pyrexia  > 37.5°C on a single reading or < 35°C
- Rigor or other signs of fever (cold, sweating, shivering)
- Any signs of infection (sore throat, cough, urinary symptoms, skin lesions)
- Diarrhoea
- Any unexplained clinical deterioration, even in the absence of fever.
- Unexplained abdominal pain
- Feeling dizzy
- Other concerns/symptoms

Focal signs of infection may or may not be present

If the patient is apyrexial but symptomatic – has the patient any of the following symptoms:

- Shortness of breath
- Cough
- Rigors
- Nausea &/or vomiting
- Diarrhoea
- Sore throat / ulcers / oral thrush
- Pain on passing urine
- Central venous catheter infection
- Confusion (may be noticed more by carer?)

Refer to relevant **symptom management section** within these guidelines.

**Note:** Patients with CLL not on treatment may be lymphopenic. Please check last lymphocyte count and discuss with haematology doctor or CNS
CVAD

Initial Assessment Questions

1. What is the device insitu?
2. How long since the device was sited?
3. Is an Ambulatory pump attached?
4. When was the CVAD last accessed?

ASK

- Redness
- Pain
- Erythema
- Exudate
- Bleeding
- Tracking

ACTION

? Infection
Attend
HODC/WSW/DBW/A&E

Surrounding area swollen/painful?

? Thrombosis
Attend
HODC/WSW/DBW/A&E

Damage to hub?
Fracture to line?

Attend
HODC/WSW/DBW/A&E

Leak of ambulatory pump?

See Ambulatory Care Guidelines
(Page 35)
Initial Assessment Questions

1. Is this a new or recurring problem?
2. Onset, frequency, intensity?
3. Alleviating/aggravating factors?
4. When did the patient receive last chemotherapy treatment or undergo transplant?
5. What chemotherapy did they receive?
6. Current use of anti emetics?
7. Any non-pharmacological interventions?
   - If so what are they? How effective are they?
8. How much food and fluid intake over the last 24 hours?
9. Any indications of disease recurrence?
10. Is the patient taking an opioid or any new medication?

Toxicity grading of nausea:

<table>
<thead>
<tr>
<th>Nausea</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of appetite without alteration</td>
<td>Oral intake decreased without significant weight loss, dehydration</td>
<td>Inadequate caloric intake or fluid intake; IV fluids, tube feeding or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to eating habits</td>
<td>or malnutrition; IV fluids indicated for &lt; 24 hours</td>
<td>TPN indicated for &gt; 24 hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NCI-CTCAE v3.0 (2003)
NAUSEA

ASK

Grade 1 & 2:
- Acute, delayed or anticipatory?
- Chemotherapy related?
- No evidence of dehydration?
- Is the patient taking any antiemetic?

Grade 3
- Evidence of dehydration?
- Unable to eat or drink for 24 hours
- Treatment change not effective within 6 hours

ACTION

Offer support, education and follow up as necessary:
- Review prescribed antiemetic therapy, dose schedule, and route using antiemetic protocol.
- Encourage correct and regular compliance of prescribed medication.
- Advise on self help measures i.e. take frequent small sips of fluids, advise to eat small amounts often, ginger biscuits or foods containing ginger, take antiemetic 20 minutes prior to meals.
- Teach patient to monitor for signs of dehydration.
- Distraction therapies to be used in addition to antiemetic therapy (i.e. music, moderate exercise, relaxation, breathing exercise).
- Encourage patient to contact department of treatment within working hours if symptoms persist or become worse.

If patient is compliant with antiemetic medication, contact the medical team to get an alternative antiemetic prescribed and faxed to the pharmacy.

Review in HODC/WSW/DBW/A&E immediately
**VOMITING**

**Initial Assessment Questions**

1. Is the patient post transplant
   
   If yes discuss with haematology doctor or CNS

2. Is this new or a recurring problem?

3. Character, colour, force, quantity of vomit?

4. Onset, frequency, intensity?

5. Alleviating/aggravating factors?

6. Current use of anti emetics?

7. Any non-pharmacological interventions?
   
   If so what are they? How effective are they?

8. How much food and fluid intake over the last 24 hours?

9. Any abdominal distension?

10. Have they also got diarrhoea or constipation?

11. Any signs of dehydration, i.e. decreased urine output, fever, thirst, dry mucus membranes, weakness, dizziness and confusion?

12. Other members of the family/household got the same symptoms?

13. Are they taking oral chemotherapy?

**Toxicity grading of vomiting:**

<table>
<thead>
<tr>
<th>Vomiting</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One episode in 24 hours</td>
<td>2 – 5 episodes in 24 hours; IV fluids indicated in &lt; 24 hours</td>
<td>&gt;6 episodes in 24 hours; IV fluids or TPN feeds indicated in &gt; 24 hours</td>
<td>Life threatening consequences</td>
</tr>
</tbody>
</table>
**VOMITING**

**Ask**

**Grade 1 & 2:**
- Acute, delayed or anticipatory?
- Chemotherapy related?
- No evidence of dehydration?
- Is the patient taking any antiemetic?

**Grade 3**
- Have symptoms lasted for more than 48 hours?
- Evidence of dehydration?
- Unable to eat or drink for 24 hours?
- Treatment change not effective within 6 hours?

**Grade 4**
- Severe vomiting
- Blood or coffee ground emesis
- Severe abdominal pain or headache
- Weak, dizzy, incoherent or responsive

**Action**

Offer support, education and follow up as necessary
- Explore self-care measures. Encourage regular use of prescribed antiemetic.
- Encourage correct and regular compliance of prescribed medication.
- Consider review of medication following antiemetic protocol.
- Advise on self help measures i.e. take frequent small sips of fluids, advise to eat small amounts often, ginger biscuits or foods containing ginger, take antiemetic one hour prior to meals.
- Teach patient to monitor for signs of dehydration.
- Distraction therapies to be used in addition to antiemetic therapy (i.e. music, moderated exercise relaxation, breathing exercise).
- Encourage patient to contact department of treatment within working hours if symptoms persist.

- Arrange review within 12 hours to include review of medication using antiemetic protocol.
- Contact keyworker/clinical area if symptoms persist.
- Encourage patient to contact department of treatment within working hours if symptoms persist or become worse.

Are they able to eat and drink?

Yes

No

**Review in HODC/WSW/DBW/A&E**

**Urgent review in HODC/WSW/DBW/A&E**
**DIARRHOEA**

**Initial Assessment Questions**

What chemotherapy is the patient on?
1. a. If Irinotecan see page 14 for advice  
   b. If Capecitabine see page 15 for advice
2. How many stools a day is patient currently experiencing?
3. How long has the patient had diarrhoea?
4. When was the patient’s last proper bowel motion?
5. Does the patient have any abdominal pain and for how long?
6. When did the patient last receive chemotherapy treatment (when if taken oral)?
7. Has the patient recently been prescribed antibiotic therapy?
8. Has the patient recently been in hospital? (E.g. Contact with C-Diff?)
9. Is the patient post bone marrow transplant? If yes see Figure 2 below.

---

**Toxicity grading of diarrhoea:**

<table>
<thead>
<tr>
<th>Diarrhoea</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increase of &lt;4 stools per day over baseline; mild increase in ostomy output compared to baseline</td>
<td>Increase of 4-6 stools per day over baseline; IV fluids indicated &lt;24 hours; moderate increase in ostomy output compared to baseline; not interfering with ADL</td>
<td>Increase &gt;7 stools per day over baseline; incontinence; IV fluids &gt;24 hours; hospitalization; severe increase in ostomy output compared to baseline; interfering with ADL</td>
<td>Life threatening consequences (e.g. homodynamic collapse)</td>
</tr>
</tbody>
</table>

---

**Note:** If the patient has Grade 2-4 diarrhoea, ask them to check their temperature as they could be at high risk of neutropenic sepsis

---

**Figure 2. Algorithm for Diarrhoea in post transplant patients only**

- How many episodes in 24 hours?
- Is it diarrhoea?
  → Watery
  → Soft
- What colour is it?
  → Green
  → Brown
- Have they been started on antibiotics?
- 2 episodes in 24 hours
  - Monitor
  - Inform doctor/CNS
  - Drop in a sample
- 4 or more episodes in 24 hours
  - Attend HODC/DBW
  - **DO NOT TAKE LOPERAMIDE**

---

NCI-CTCAE v 3.0 (2003)
**DIARRHOEA**

**Grade 1 – 2 Diarrhoea**

**Ask**

- What chemotherapy regimen is the patient on?

**Action**

1. If on Irinotecan – see guidelines page 14.
2. If on Capecitabine – see guidelines page 15.
3. If on 5fu infusor consider taking advice for disconnection of infusor (this must only be performed by trained professionals/carer).
4. If patient is pyrexial see infection guidelines page 4 & 5.
5. Obtain stool specimen.

**IF NONE OF THE ABOVE.....**

Is the patient taking Loperamide? No

- Discuss with medical doctor. ? obtain prescription for Loperamide and fax to patient’s pharmacy.

Yes

- Assess in HODW/WSW/DBW/A&E

After every episode?

Yes

- Advise patient to take Loperamide after every episode of diarrhoea until bowel motions have returned to baseline

No

**REMEMBER TO ALSO ASK.....**

Are they eating and drinking? (At least 2-3 litres per day)

Yes

- No intervention required at present

No

- Advise to drink more and arrange review within 12-24 hours
### DIARRHOEA

#### Grade 3 Diarrhoea

<table>
<thead>
<tr>
<th>ASK</th>
<th>ACTION</th>
</tr>
</thead>
</table>
| What chemotherapy regimen is the patient on?                        | 1. If on Irinotecan refer to guideline on page 14.  
2. If on Capecitabine refer to guideline on page 15.  
3. If on 5fu infusor arrange for disconnection                      |
| Are they eating? Are they drinking more than 2-3 litres per day?    | Patient must be assessed in an isolation room                                                                                                                                                           |
| Are they taking Loperamide and Codeine Phosphate?                   | Bring to isolation room in HODC/WSW/DBW/A&E for assessment.                                                                                                                                             |

#### Grade 4 Diarrhoea

Arrange for an immediate assessment in HODC/WSW/DBW/A&E
TREATMENT OF DIARRHOEA FOR PATIENTS ON IRINOTECAN (CPT11)

Treatment with Irinotecan may cause two different kinds of diarrhoea, which can be distinguished by their time of starting.

1. **Early diarrhoea** starts less than 24 hours after an infusion of Irinotecan (this can start within 30 minutes of infusion).

2. **Delayed diarrhoea** starts more than 24 hours after infusion of Irinotecan.

**ASK**

- When was the last infusion of Irinotecan?
- When did the diarrhoea start?

**ACTION**

- Advise/discuss discharge advice:
  - Take 2 Loperamide tablets straight away.
  - Take 1 Loperamide tablet every 2 hours until 12 hours after the last liquid stool.
  - Do not take these tablets for more than 48 hours at this dosage.
  - Drink large amounts of fluid immediately (water, soda water, soups, dioralytes).
  - Do not take any treatment for diarrhoea other than that given by hospital staff familiar with your chemotherapy regimen.

**Further advice**

If diarrhoea continues and or the patient has any other symptoms:
- Nausea and vomiting
- Pyrexia
- Still has diarrhoea 48 hours after starting treatment for delayed diarrhoea

Advise patient to contact ward again. **Arrange immediate admission to Oncology/Haematology/designated Medical Ward for assessment.**

**N.B.** Ask the patient if they have any other related symptoms such as sweating/abdominal cramps/watering eyes/visual disturbances/dizziness/low blood pressure/feeling generally unwell/excessive mouth watering.

**N.B.** Highlight to the patient that this specific treatment (of Loperamide) is higher than the dosage recommended in the leaflet in the packet of hospital tablets.
TREATMENT OF DIARRHOEA FOR PATIENTS ON CAPECITABINE (XELODA)

If the patient has any of the following symptoms:

**ASK**

- Diarrhoea: If the patient has had more than 4 bowel movements each day or any diarrhoea at night since taking Capecitabine, or diarrhoea at night?
- Vomiting: If the patient has been vomiting more than once in a 24 hour time period?
- Nausea: If the patient feels the need to be sick? This may result in a reduced appetite.
- Stomatitis: If the patient has pain, redness, swelling or sores in their mouth?
- Hand and foot skin reaction: If the patient has pain, swelling and redness of their hands and or feet?
- Fever or infection: If the patient has a temperature of 38°C or greater or other signs of infection?

**ACTION**

1. Advise patient to STOP Capecitabine and refer to Capecitabine guidelines.
2. Use clinical judgement and refer to relevant symptom management guidelines for further advice and consideration of admitting to hospital.
3. Complete telephone proforma.
**Constipation**

**Initial Assessment Questions**

1. What cancer is the patient being treated for?
2. Ask the patient when was the last bowel movement?
3. Ask what are ‘normal’ bowel habits?
4. Review patient’s current food and fluid intake?
   - What medication is the patient taking (if any)?
   - Is the patient taking Opioids?
5. Is the patient on any laxatives?
6. What chemotherapy is the patient being administered? (e.g. Vinca alkaloids)
7. When did the patient receive the last chemotherapy treatment?
8. Is the patient having any overflow?

**Toxicity grading of constipation:**

<table>
<thead>
<tr>
<th>Constipation</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Occasional or intermittent symptoms; occasional use of stool softeners,</td>
<td>Persistent symptoms with regular use of laxatives</td>
<td>Symptoms interfering with ADL</td>
<td>Life threatening consequences (e.g. obstruction)</td>
</tr>
<tr>
<td></td>
<td>laxatives, dietary modification</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NCI-CTCAE v3.0 (2003)

*N.B. If patient is potentially neutropenic, lymphopenic, or post BMT, the use of suppositories and enemas MUST BE AVOIDED (Increased risk of fatal gram-negative sepsis) therefore advise oral laxatives.*
Note on laxatives

- Bulk forming laxatives: Fybogel
- Osmotic laxatives: Movical, Lactulose
- Stimulant laxatives: Senna (night)

**Constipation**

**Ask**

**Grade 1 & 2 with:**
- Dry/hard stool
- Increased anorexia
- Decreased fluid intake
- No bowel movement for 2 days

**Action**

- Offer support, education and follow up as necessary
- High fibre diet
- Increase fluid intake
- Exercise
- Laxatives
- Encourage patient to contact department of treatment within working hours if symptoms persist or become worse

**Grade 3 with:**
- Nausea and or vomiting
- Increasing abdominal pain
- No bowel movement for more than 3 days

- Review prescribed stool softeners and laxatives, including concomitant medication that could exacerbate condition.
- Advise proper use of daily bowel regimen.
- Requires medical attention within the next 24 hours

**Grade 4 with:**
- Severe abdominal pain
- Nausea and or vomiting
- Faecal smelling vomit
- Severe rigid abdominal distension
- Recent abdominal surgery

- Attend HODC/WSW/DBW/A&E/nearest hospital immediately
**MUCOSITIS**

**Initial Assessment Questions**

1. Do you have pain in your mouth?
2. Does eating or swallowing make the pain worse?
3. Is there any bleeding in your mouth and if so, for how long?
4. Do you have any blisters, ulcers or white patchy areas on your tongue, lips or in your mouth and if so, for how long?
5. Do you have any saliva in your mouth?
   - Is it thicker than normal?
6. Are you able to eat and drink?
   - Has this caused any change to your normal dietary intake and have you had any weight loss?
7. If dentures are worn do they aggravate any symptoms in your mouth?
8. Are you using any mouthwashes, analgesia or other treatments within the mouth?

Toxicity grading of dry mouth or xerostomia:

<table>
<thead>
<tr>
<th>Dry mouth Xerostomia</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Symptomatic (dry/thick saliva) without significant dietary alteration</td>
<td>Symptomatic and significant oral intake alteration (i.e. copious water, other lubricants, diet limited to purées and or soft moist foods)</td>
<td>Symptoms leading to inability to adequately aliment. IV fluids, TPN, tube feeding indicated</td>
<td>Alimentation not possible</td>
</tr>
<tr>
<td>Mucositis</td>
<td>Soreness or Erythema</td>
<td>Erythema, ulcers, can eat and drink</td>
<td>Erythema, ulcers, can only take fluids</td>
<td></td>
</tr>
</tbody>
</table>

*NCI-CTCAE v3.0 (2003)*

*N.B. Patients with grade 2-4 mucositis, check temperature as may be at risk of neutropenic sepsis. See relevant guidelines.*
**MUCOSITIS**

**Grade 1 & 2:**
- Painless ulcers, Erythema.
- Mild soreness in absence of lesions.

**ASK**

Offer support, education and follow up as necessary
- Advice on relevant mouth care and frequency required. (Use soft toothbrush at least 4 times daily, brush tongue, avoid alcohol based mouthwashes, how to keep mouth moist, etc.)
- Arrange for prescription for BMX if necessary.
- Encourage good oral intake of fluids and soft diet.
- Check if patient has oral Candida.
- Arrange for review and prescription of antifungal medication.

If post transplant, neutropenic or lymphopenic discuss with haematology doctor and CNS as ulcers may be viral and antiviral treatment may need to be increased.
Encourage patient to contact department of treatment within working hours if symptoms persist, or become worse.

**Action**

**Grade 3:**
- Evidence of dehydration
- Unable to eat or drink for 24 hours
- Treatment change not effective within 6 hours
- Whitish covering of oral mucosa

Requires medical attention within the next 24 hours

**Grade 4:**
- Temperature >38°C
- Unable to drink fluids
- Respiratory distress
- Bleeding from oral mucosa
- Pain not controlled by current analgesia
- Blistered or cracked tongue

**Seek immediate medical attention**
Patient to attend HODC/WSW/DBU/A&E for assessment +/- admission

HOPe Directorate, St. James’s Hospital V2 2012
<table>
<thead>
<tr>
<th>Initial Assessment Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When did your breathlessness start?</td>
</tr>
</tbody>
</table>
| 2. What type cancer do you have?  
Are you post transplant? |
| 3. Do you suffer with any breathing problems? i.e. asthma, emphysema, etc. |
| 4. Right now how is your breathing on a scale of 0-10?  
a. At its worst?  
b. At its best? |
| 5. Can you describe your breathlessness?  
What does it feel like? |
| 6. How long does your breathlessness last?  
a. Is it constant?  
b. Does it come and go? |
| 7. How severe is it? (Can the patient talk complete sentences/how far can they walk compared to normal limits) |
| 8. What makes it better? (Medications, puffers, oxygen, fresh air, fan, rest, breathing exercises, or when the patient relaxes) |
| 9. Is there anything else that is occurring with your breathlessness? (fever, pain, chest pain, cough, wheezing, stridor, mental confusion, fatigue) |
| 10. What chemotherapy is the patient on? |
| 11. Are there any community based nurses calling to the patient at home? |
Toxicity grading of breathlessness or dyspnoea:

<table>
<thead>
<tr>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyspnoea on exertion but can walk one flight of stairs without stopping</td>
<td>Dyspnoea on exertion but unable to walk one flight of stairs or a short distance without stopping.</td>
<td>Dyspnoea with ADL</td>
<td>Dyspnoea at rest. Severely debilitating</td>
</tr>
</tbody>
</table>

## Breathlessness

### Ask

**Grade 1:**
- Is the patient complaining of breathlessness?
- Are symptoms unchanged from usual chronic symptoms? (i.e. COPD, emphysema, asthma)

**Grade 2 & 3:**
- Is the patient complaining of feeling breathless?
- Are symptoms a new onset or change to regular (usual) breathing pattern? (i.e. increased SOB, laboured breathing while awake and asleep, pauses when talking)

**Grade 4:**
- Acute episode or exacerbation of breathlessness
- New acute onset of chest pain

### Action

**Offer support, education as necessary:**
- Consider comfort measures – positioning, relaxation, distraction, breathing retraining techniques, prescribed medication and oxygen.
- Review preventative measures – breathing exercises, avoid symptom triggers as much as possible, pace and prioritize activities.
- Record episodes of breathlessness and self-interventions – at rest, medications, keeping track of number of episodes.
- Document adverse effects of treatment as needed

**Requires medical attention within the next 24 hours**

Assess for:
- Symptoms of anaemia
- Signs of chesty infection
- Pulmonary embolism
- Pulmonary oedema or pleural effusion

Arrange for:
- FBC, Group and hold
- Sputum specimen
- Radiographic examination/CPTA

**Requires immediate medical attention**
- Describes pain as central crushing chest pain?

Inform patient to call 999 immediately

---

**Note:** For Haematology patient’s that are neutropenic, lymphopenic, post transplant or on treatment: Breathlessness and a dry cough may be signs of PCP. Check if patient is on Septrin/Pentamidine or Atrovaquone and discuss with the haematology registrar or CNS
HAEMATOLOGY ONCOLOGY TELEPHONE TRIAGE GUIDELINES

FA T I G U E

Initial Assessment Questions

1. Onset, duration and intensity of fatigue?

2. Any other symptoms: signs of bleeding, skin membrane pallor, feeling cold, feeling faint, dizziness, short of breath (at rest or with activity), rapid heartbeat, chest pain, leg heaviness?

3. Does the patient feel rested after a night’s sleep?

4. Ability to carry out ADL’s, how has this changed?

5. Does anything help alleviate your fatigue?

6. Any difficulty concentrating?

7. Do you feel sad, anxious, stressed?

8. Have you been able to eat and drink normally?
   Have you had any appetite or weight changes?

9. Treatment history and current medications?

10. Have you had a blood transfusion and if so when?

Toxicity grading of fatigue:

<table>
<thead>
<tr>
<th>Fatigue</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mild fatigue over baseline</td>
<td>Moderate or causing difficulty performing ADL’s</td>
<td>Severe fatigue interfering with ADL’s</td>
<td>Disabling</td>
</tr>
</tbody>
</table>

NCI-CTCAE v3.0 (2003)

Note to Nurse
Ask yourself is palliative care involved?
Check diagnosis – patients often first experience extreme fatigue when the dying process is starting.

Definition of fatigue
“A condition characterised by distress and decreased functional status related to a decrease in energy. The specific manifestations of which may be, physical, mental or emotional.” (Pickard-Holly, S. 1991; Stones, Richards, Hardy 1998).
**FATIGUE**

**Ask**

**Grade 1:**
- Ability to carry out ADLs

**Grade 3:**
- Severe fatigue
- Functional deficits affecting QOL
- Exertional SOB

**Grade 4:**
- Sudden onset of severe fatigue
- Chest pain
- Tachycardia
- Shortness of breath at rest
- Haemorrhage or rapid loss of blood

**Action**

Offer support, education as necessary:
- Explanation regarding normal/expected fatigue associated with treatment/disease.
- Employ energy conservation strategies (set priorities, pace activities, delegate as needed).
- Schedule rest periods throughout the day.
- Explore restorative therapies i.e. games, music, reading.
- Stress management options, relaxation techniques.
- Offer dietary advice.
- Consider use of diary to assess daily activity.
- Document and reassess at next appointment.
- Encourage patient to contact department of treatment within working hours if symptoms persist.

- Offer support and education.
- Arrange medical attention within next 24 hours.
- Assess treatment history and current medication.
- Obtain required blood samples (FBC, group and hold).

Following assessment address identified causes:
- Pain management – assess analgesia requirements
- Correct anaemia with transfusion
- Recognition/treatment of depression
- Address sleeping habits
- Consider electrolyte imbalance and correct

**Straight to A&E**

If the patient is experiencing disabling symptoms where they cannot carry out any self-care and are totally confined to bed or chair, direct admission has to be carefully considered. Discussion with the patient’s clinician (clinician on call if out of hours) needs to take place to assess the appropriateness of this action.
SKIN RASHES

Initial Assessment Questions

1. How long have they had the rash?

2. Where on the body is it?
   Is it localised or extensive?

3. Is the rash affecting the face?
   Are there any changes to the patient’s vision? (ophthalmic shingles)

4. Is it painful?

5. What regimen are they on and when was it last given? (?Drug related)
   a. Cetuximab/Erbitux?
   b. Panitumumab?
   c. Oral chemotherapy?

   If yes please see page 28 on EGFR rash assessment and management.

6. Have they had a bone marrow transplant? If yes:
   How long post transplant?
   What immunosuppression are they on?
   History of GVHD?
   Any changes in medication? (e.g. Septrin added?)
   Is it itchy? (GVHD not typically itchy, but can be)
   Ask patient to check soles of feet/palms of hand and behind ears.

<table>
<thead>
<tr>
<th>Rash</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macular or popular eruption or Erythema without associated symptoms</td>
<td>Macular or popular eruption or Erythema with associated symptoms. Rash covering &lt;50% of body surface area (BSA)</td>
<td>Severe generalised erythroderma or macular, popular or vesicular eruption: &gt;50% BSA</td>
<td>Generalised exfoliative, ulcerative, or bullous dermatitis</td>
<td></td>
</tr>
</tbody>
</table>

NCI-CTCAE v3.0 (2003)
**SKIN RASHES**

**ASK**

- Post BMT

**ACTION**

Consult Haematology registrar of CNS

- Is the patient on: Chlorambucil Lenalidomide

**ACTION**

Discuss with Haematology registrar of CNS.
If out of hours advise to stop the drug and contact the team the next morning.

- Painful rash-vesicular blisters/lesions

**ACTION**

Attend to clinical area side room
  - ? Shingles
  - ? Patient on antivirals

- Extensive rash Symptomatic

**ACTION**

Advise to apply topical calamine, take antihistamine.
Seek further advice if worsens or becomes **painful**

- Localised rash Asymptomatic

**ACTION**

Advise to observe for changes
SKIN RASHES

Assessment and management of anti-EGFR related skin rash

1. Is the patient carrying out general skin care as follows (regardless of any rash)

- SPF
- Mild soaps when cleansing the skin
- Avoid harsh laundry detergents
- Use tepid water when showering/bathing
- Aveeno oatmeal skin care range
- Avoid tight shoes

<table>
<thead>
<tr>
<th>SPF</th>
<th>Mild soaps</th>
<th>Harsh detergents</th>
<th>Tepid water</th>
<th>Aveeno range</th>
<th>Tight shoes</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
</tbody>
</table>

Follow advice above

2. Rash from anti-EGFR is either grade 1,2, or 3 and is acneiform in description

<table>
<thead>
<tr>
<th>EGFR Rash</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papules or pustules on face and trunk, not itchy, not painful, not affecting QOL</td>
<td>Papules or pustules on face and trunk which may not be itchy, painful and disturbing QOL e.g. affecting sleep, or going out in public.</td>
<td>Papules or pustules on face and or trunk which are severe, painful itchy and seriously affecting QOL</td>
<td></td>
</tr>
</tbody>
</table>

Yes

Follow advice above

No

Grade rash and treat appropriately
SKIN RASHES

ASK

Grade 1
EGFR Rash

ACTION

- Metronidazole twice a day
- Skin care advice as above

Grade 2
EGFR Rash

- Metronidazole twice a day
- Minocycline 100mgs once a day
- Antihistamine if itchy

Grade 3
EGFR Rash

- Metronidazole up to five times a day
- Minocycline 100mgs if not already on it and if on it increase to 200mgs daily
- Saline compresses for 15 minutes twice a day
- Antihistamine
- Consider dose adjustment or delay on next visit
## ASCITIES

### Initial Assessment Questions

1. What is the patient’s diagnosis and treatment?

2. Past medical history

3. What medications is the patient taking?

4. Ask the patient to describe their symptoms?
   a. Shortness of breath?
   b. Gastric reflux?
   c. Abdominal distension?
   d. Abdominal or back pain
   e. Weight gain?
   f. Decreased appetite?
   g. Lower extremity odema?
   h. Vomiting?

5. Onset and duration?

6. Relieving factors?
ASCITIES

SIGNS AND SYMPTOMS

- Increase in abdominal girth
- Abdominal fullness, bloating, heaviness or tightness
- Ingestion
- Nausea and vomiting
- Increased frequency of vomiting

ACTION

- Come to HODC for assessment on next clinic

SIGNS AND SYMPTOMS

- Swelling of ankles
- Inability to eat or drink for 24 hours
- Weight gain
- Decrease in ability to perform ADLs
- Inability to sleep or rest due to shortness of breath or abdominal discomfort
- Lack of bowel movement

ACTION

- Come to HODC for assessment

SIGNS AND SYMPTOMS

- Difficulty breathing
- Abdominal discomfort
- Weight gain
- Uncontrolled nausea and vomiting for >24 hours
- Change in mental status
- Inability to perform ADLs

ACTION

- Advise to come to HODC/WSW/DBU/A&E for assessment

SIGNS AND SYMPTOMS

- Severe shortness of breath
- Acute abdominal pain
- Unresponsiveness
- Temperature >38°C

ACTION

- Seek Emergency care immediately
MOOD ALTERATION

Initial Assessment Questions

1. Is this a new problem?

2. Any physical:
   a. Shortness of breath?  b. Sleep disturbances?  c. Dizziness or muscle tension?

3. Any psychological:

4. What are the sources of patient support?

5. Does the patient have a history of depression/any psychiatric illness?

6. Is the patient taking any new medications?

7. Is the patient on steroids (including inhaled steroids)? If yes:
   a. What dose are they taking?
   b. When did they commence?
   c. When was the dose last reduced or increased?
   d. Was the dose weaned or did they just stop as part of a treatment regimen?

8. Is palliative care involved with the patient?

9. Is the patient starting to die?

Grading of Mood Alteration:

<table>
<thead>
<tr>
<th>Mood Alteration</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
<th>Grade 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild mood alteration not interfering with function</td>
<td>Moderate mood alteration interfering with function, but not interfering with ADL; medication indicated</td>
<td>Severe mood alteration interfering with ADL</td>
<td>Suicidal ideation; danger to self or others</td>
<td>Death</td>
<td></td>
</tr>
</tbody>
</table>

NCI-CTCAE v3.0 (2003)
Mood Alteration

**Grade**

**Action**

- Advise to use the support of family and friends
- Refer to ARC House or ICS or other support groups
- MSW

*Note: Consider steroid induced mood alteration*

**Grade 1 & 2**

**Grade 3**

Persistent or >24 hours, refer to psycho-oncology team

**Grade 4**

Emergency Care
Initial Assessment Questions

1. What is your diagnosis?
   What chemotherapy are you on?

2. History of pain?

3. Character of pain:
   a. Sudden onset?  
   b. Loss of mobility?  
   c. Chest pain?

4. Location of pain?

5. Onset and duration?

6. Intensity (pain scale 0-10)?

7. Aggravating and relieving factors?

8. Current pain medication?

9. Is palliative care involved?

Patients on **GCSF** may complain of back pain. Advise paracetamol if patient is well and **not to stop GCSF**

**THINK**  
**TRAMADOL**  

**AVOID**  
**PARACETAMOL SOLPEDINE**
### PAIN

#### Signs and Symptoms

<table>
<thead>
<tr>
<th>Mild aches and pains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild to moderate pain that has been increasing.</td>
</tr>
<tr>
<td>Pain that is not controlled by current regimen.</td>
</tr>
<tr>
<td>Pain that is interfering with activity or sleep</td>
</tr>
<tr>
<td>Sudden onset of moderate to severe pain</td>
</tr>
<tr>
<td>Pain not responsive to current medication regimen</td>
</tr>
<tr>
<td>Pain that interferes with mobility</td>
</tr>
<tr>
<td>Describe signs or symptoms of acute injury, spinal cord compression, pathological fracture, or other life threatening problem.</td>
</tr>
<tr>
<td>Sudden onset of severe weakness or unrelenting localized pain: inability to ambulate, decreased sensation in extremities, loss of control of bowel or bladder</td>
</tr>
<tr>
<td>Chest pain</td>
</tr>
<tr>
<td>Severe headache</td>
</tr>
</tbody>
</table>

#### Action

| Advise appropriately. Notify hospital if no improvement |
| Discuss with medical team or CNS |
| Attend HODC/WSW/DBU/A&E as advised |
| Seek Emergency Care Immediately |
| (? Haemorrhage – last platelet count) |
**AMBULATORY PUMP**

**Initial Assessment Questions**

1. Does the patient have a 5fu pump attached?
2. How many days has it been attached?
3. What chemotherapy regimen is the person on?

---

**Is the pump leaking?**

- **Yes**
  1. Clamp the pump
  2. Clean up the leak using the home spillage kit
  3. Come to HODC/WSW for assessment

- **No**

---

**Is the pump infusing?**

- **Yes**
- **No**

**How long has it been on for?**

- **>46 hours**
  - Disconnect (if 5fu pump)
- **<46 hours**
  - Come to HODC for assessment

---

**HOPE Directorate, St. James’s Hospital V2 2012**
**PERIPHERAL NEUROPATHY**

**Initial Assessment Questions**

1. What are the patient’s cancer diagnosis and treatment?
2. What medication is the patient taking?
3. Ask the patient to describe their symptoms in detail:
   a. Sensations?
   b. Any associated symptoms?
4. Obtain a history including:
   a. Precipitating factors
   b. Onset and duration?
   c. Relieving factors?
5. Past medical history?
6. Changes to ADLs?

<table>
<thead>
<tr>
<th>Paresthesia</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild symptoms</td>
<td>Moderate symptoms; limiting instrumental ADL</td>
<td>Severe symptoms; limiting self care ADL</td>
<td>Disabling</td>
<td></td>
</tr>
</tbody>
</table>

NCI-CTCAE v3.0 (2003)

**GRADE**

- Grade 1
  - Advise to report to medical team on next visit
  - Reassure patient it is a side effect of chemotherapy

- Grade 2 & 3
  - Advise to report to medical team on next visit.
  - Reassure patient it is a side effect of chemotherapy
  - Encourage to moisturise area 4 times a day to increase circulation to the peripheries

- Grade 4
  - Review immediately in HODC/WSW/DBW/A&E
REFERENCES


## APPENDIX 1. ONCOLOGY TELEPHONE TRIAGE FORM

### Telephone Consultation Flowsheet

<table>
<thead>
<tr>
<th>Date</th>
<th>Person Taking Call</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time Spent on call</th>
<th>Patient Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Diagnosis

- [ ] Bladder Cancer
- [ ] Brain Cancer
- [ ] Breast Cancer
- [ ] Cervical Cancer
- [ ] Colorectal Cancer
- [ ] Endometrial Cancer
- [ ] Esophageal Cancer
- [ ] Hodgkin's Disease
- [ ] Lung Cancer
- [ ] Metastatic Disease
- [ ] Non-Hodgkin's Lymphoma
- [ ] Ovarian Cancer
- [ ] Pancreatic Cancer
- [ ] Sarcoma
- [ ] Head and Neck Cancer
- [ ] Other
- [ ] Info Co Unknown Primary
- [ ] Diagnosis in Progress

### Current Treatment


### Main Complaint


### Onset


### Duration


### Treatment Tried at Home


### Team Members Consulted


## APPENDIX 1. ONCOLOGY TELEPHONE TRIAGE FORM

### Recommendations

<table>
<thead>
<tr>
<th>Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Follow Up

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Instructions/Information</th>
<th>Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX 2. HAEMATOLOGY TELEPHONE TRIAGE FORM

**Telephone Consultation Flowchart**

<table>
<thead>
<tr>
<th>Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Taking the call</td>
</tr>
<tr>
<td>Patients Contact Number</td>
</tr>
</tbody>
</table>

**Condition**

- Acute Lymphoblastic Leukaemia
- Acute Myeloid Leukaemia
- Aplastic Anaemia
- Burkitt Lymphoma
- Chronic myeloid Leukaemia
- Chronic Myelomonocytic Leukaemia
- Chronic Lymphocytic Leukaemia
- Essential Thrombocythaemia
- Hailey Cell Leukaemia
- Hodgkin’s Lymphoma
- Non Hodgkins Lymphoma
- Multiple Myeloma
- Myelofibrosis
- Myelodysplastic Disease
- Malignant Lymphoma
- Malignant Myeloma
- Polycythaemia Rubra Vera
- Waldenström Macroglobulinemia
- Haemoglobinopathy
- Sickle Cell Anaemia
- Neutropenia
- Other

**Current Treatment**

**Main Complaint**

**Onset** | **Duration**

**Treatment Tried at Home**

**Team Members Consulted**

---

HOPe Directorate, St. James’s Hospital V2 2012
### Recommendations and Follow Up

#### Recommendations

- [ ]

#### Follow Up

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Follow up Plan</th>
<th>Signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>