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# A Study to Assess Effectiveness of VATP on Knowledge Regarding Cervical Cancer & its Prevention by HPV Vaccine Among Adolescent Girls, Hyderabad

**Keerthi Samuel Kalabathula**

**Abstract**

***Introduction***

***Cancer*:** It is an oncogene regulated cell growth in a positive fashion. Oncogenes include transforming genes of Viruses and normal cellular genes that are activated by mutations to promote cell growth to a partly malignant behavior.

***Cervical Cancer*** is defined as an abnormal cell proliferation in the cervix (or) abnormal cell growth in the cervix'. This study is aimed to assess the effectiveness of VATP on knowledge regarding cervical cancer and its prevention through HPV vaccine among adolescent girls in selected college, Hyderabad.

***Methods*:** Subjects of this study were 60 adolescent girls. Data was collected using structured questionnaire.

***Results*:** The findings showed that the VATP was effective increasing the knowledge of adolescent girls.

***Conclusion*:** The video assisted teaching increased the knowledge levels of adolescent girls regarding cervical cancer and its prevention through HPV vaccine.

**Keywords:** Cervical cancer; Human Papilloma Virus vaccine (HPV); Video assisted Teaching Programme (VATP); Adolescent girls; Knowledge.

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## Introduction

*Cancer* it is an oncogene regulated cell growth in a positive fashion. Oncogenes include transforming genes of Viruses and normal cellular genes that are activated by mutations to promote cell growth to a partly malignant behavior. It needs one mutational events for its gain of function'.

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*Cervical cancer* is defined as an abnormal cell proliferation in the cervix (or) abnormal cell growth in the cervix'.

Cervical cancer is the fifth most common cancer in humans, the second most common cancer in women worldwide and the most common cause of death due to cancer in the developing countries. Sexually transmitted human papilloma virus (HPV) infection is the most important risk factor for cervical intraepithelial neoplasia and invasive cervical cancer. The worldwide incidence of cervical cancer is approximately 510,000 new cases annually, with approximately 288,000 deaths worldwide. Unlike many other cancers, cervical cancer occurs early and strikes at the productive period of a woman's life. The incidence rises in 30–34 years of age and peaks

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at 55–65 years, with a median age of 38 years (age 21–67 years). In today's world, 83 % of cases are in the developing world, and 85 % of deaths are associated with cervical cancer. The South Asian region harbors one fourth of the burden of cervical cancer. In India alone there are an estimated 132,000 new cases and 74,000 deaths each year (WHO 2009). The most important cause of cervical cancer is infection with a high risk type of human papilloma virus. The types HPV most commonly linked with cervical cancer are HPV 16 and HPV 18, but several other high risk types contribute to cancer as well. HPV infection is extremely common and generally occurs soon after an individual becomes sexually active. One of the most important prevention of cervical cancer has been the development of the Vaccine for HPV, Gardasil, it is effective against for HPV subtypes, including 16 & 18. The FDA has approved the vaccination which is given as a series of three injections, for girls aged 9 to 26 years. The Vaccine will be most effective when given before a young women has any sexual contact. Although effective, it will not protect against all types of HPV and will not prevent all cases of cervical cancer, so routine pap testing is still required. Research continues on other HPV Vaccines and on vaccinating men, who severe as the vector for HPV in most infected women.

The World Bank (2000) argues that education can protect against HPV infection through information and knowledge that may affect a long term behavioral change particularly for women by "Reducing the Social and economic Vulnerability that exposes high risk for cervical cancer".

According to "National Cancer Control Programme" the current status and strategies, reveals that cancer has been one of the tenth leading cause of death in India. It is estimated that there are nearly 2-2.5 million cancer cases. Over 7 lakh new cases and 3 lakh deaths occur annually due to cancer. National cancer Registration programme indicate that the leading sites of cancer are cervix, breast and oral cavity among woman. Cervical cancer is the second common form of gynecologic cancer with advanced disease often associated with postcoital bleeding, pelvic or sciatic pain, and a thin watery discharge. Guidelines recommend that screening begins when a woman becomes sexually active or by age 18 years.

## Methodology

The research approach adopted for this study was quantitative research approach and the design was pre experimental one group pretest posttest design. 60 samples were selected using simple random sampling. The study setting was a selected degree college, Hyderabad. The sample consisted of 60 adolescent girls Administrative approval to conduct the study was taken from the Principal of the selected degree college. The students were given a questionnaire consisting of 30 questions in part B and part C. Part A consisted of 8 demographic variables. Part B consisted of the questions related to knowledge regarding cervical cancer with 15 questions.. Part C consisted of the questions related to knowledge regarding prevention of cervical cancer using HPV vaccine with 15 questionsthe data was collected from22/2/2016 to 26/2/16. The purpose of the study was explained and an informed consent was taken from the all the respondents.

Include the details of the intervention given for the study group

## Results

**Table 1** The collected data were analyzed and interpreted in accordance with objectives using inferential and descriptive statistics.

| Demographic variable | Frequency | Percentage |
|---|---|---|
| **Age** | | |
| 15 years | 3 | 5 |
| 16 years | 17 | 28 |
| 17 years | 26 | 43 |
| 18 years | 14 | 24 |
| **Religion** | | |
| Hindus | 37 | 62 |
| Christians | 18 | 30 |
| Muslims | 5 | 8 |
| Others | – | – |
| **Socio-economic status** | | |
| Lower middle class | 1 | 2 |
| Middle class | 42 | 70 |
| Upper middle class | 15 | 25 |
| Higher class | 2 | 3 |
| **Educational Status of the Mother** | | |
| Illiterate | 2 | 3 |
| Primary Education | 2 | 3 |
| High School Education. | 16 | 27 |
| Graduation | 30 | 50 |
| Post-Graduation | 10 | 17 |
| **Educational Status of the Father** | | |
| Illiterate | – | – |
| Primary Education | – | – |
| High School Education. | 12 | 20 |
| Graduation | 25 | 42 |
| Post-Graduation | 23 | 38 |
| **View towards Vaccination** | | |
| Positive View | 59 | 98 |
| Negative | 1 | 2 |
| **Information Regarding Cervical Cancer and HPV Vaccine.** | | |
| Yes | 23 | 38 |

| | | |
|---|---|---|
| No | 37 | 62 |
| **Source of Information** | | |
| Books | 10 | 46 |
| Internet | 6 | 25 |
| Television. | 1 | 4 |
| Mass Media | 6 | 25 |

**Table 1** Showed majority of the adolescent girls were 26 (43%) were 17 years old, 37 (62%) were hindus, 42 (70%) belong to middle class, 30 (50%) of the samples mothers were graduates, 25 (42%) of the samples fathers were graduates,59(98%) of them had positive attitude towards vaccination,37(62%) hadprevious knowledge regarding cervical cacncer and HPV vaccine,10(46%) sourced their knowledge from books.

**Table 2** Percentage distribution of adolescent girls according to Knowledge scores in pre and post test. (n=60)

| Level of Knowledge | Pre test | Post test |
|---|---|---|
| Below Average (0-50%) | 55% | 2% |
| Average (51%-75%) | 45% | 7% |
| Above Average (>75%) | – | 91% |

**Table 2** Indicates pre and posttest knowledge scores among adolescent girls. The pretest shows 55% of adolescent girls were in below average, 45% have average knowledge and none of workers were in above average. Further posttest shows 2% of adolescent girls have scored below average and 7% scored average and remaining 91% have scored above average. Therefore, there is a significant and considerable improvement in posttest knowledge scores compare to pretest. Thus the video assisted teaching programme was effective in increasing their knowledge scores.

**Table 3** Overall knowledge gain with video assisted teaching programme on cervical cancer and its prevention through HPV vaccine in terms of Mean and paired "t" test. (n=60)

| Knowledge scores | Pre-test | Post test |
|---|---|---|
| Mean | 21.7 | 46.75 |
| Mean percentage | 36% | 78% |
| Standard deviation | 1 | 11.7 |
| Paired "t" test | 25 | |
| df | 59 | |
| Table " t" value | 2.02 | |

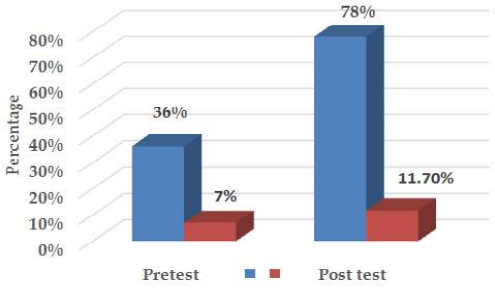


**Table 3** Shows that there was an improvement in Mean scores of respondents that is 46.75. The calculated "t" value is 25, which is very much higher than the table value 2.02. It shows that there is significant difference in pretest and posttest knowledge scores.

Since the video assisted teaching programme on cervical cancer and its prevention through HPV vaccine is highly effective among the adolescent girls, the stated null hypothesis for the study "there will be no significant difference in pretest and posttest knowledge scores of brick makers on prevention of occupational hazards" can be rejected.

**Table 4** Chi-square values of pretest Knowledge scores of adolescent girls with their demographic variables.

| Demographic variable | Chi square | Df | Table value | Level of Significance |
|---|---|---|---|---|
| Age | 3.93 | 6 | 12.59 | NS |
| Religion | 1.02 | 6 | 12.59 | NS |
| Socio-economic status. | 0.62 | 6 | 12.59 | NS |
| Educational status of the Mother. | 4.8 | 8 | 15.51 | NS |
| Educational status of the Father. | 0.5 | 8 | 15.51 | NS |
| View towards vaccination | 1.8 | 2 | 5.99 | NS |
| Information regarding cervical cancer & HPV vaccine. | 0.11 | 2 | 5.99 | NS |
| Source of information. | 2.5 | 6 | 12.59 | NS |

**Table 4** Shows the chi square values computed for knowledge data in pretest found that calculated values are less than the table value at 5% level of significance. This implies that there is no significant association existing between knowledge of adolescent girls regarding cervical cancer and its prevention through HPV vaccine with selected demographic variables like age, religion, socio-economic status, educational status of the mother, educational status of the father, view towards vaccination, information regarding cervical cancer and its prevention through HPV vaccine and source of information.

## Conclusion

The present study attempted to assess the effectiveness of video assisted teaching programme on cervical cancer and its prevention through HPV vaccine among adolescent girls and the study findings concluded that if there are effective video assisted teaching programs the knowledge among adolescent girls can be improved.

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# Restless Legs Syndrome (RLS): Triggers, Home Remedies and Treatment

**Veerabhadrappa G Mendagudli**

**Abstract**

***Restless Legs Syndrome:*** is a disorder in which you have an uncontrollable impulse to move your legs, usually in response to an unpleasant sensation. It usually happens when you're seated or lying down in the evening or at night. Moving around temporarily alleviates the uncomfortable sensation. Restless legs syndrome, also known as Willis-Ekbom sickness, can strike at any age and worsens with time. It can interfere with daily tasks by disrupting sleep. Simple self-care and lifestyle adjustments may be beneficial in alleviating symptoms. Medications also help many people with RLS.

**Keywords:** Restless Less Syndrome (RLS); Willis-Ekbom sickness; Twitching; Worsening; Home remedies.

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## Introduction

The great majority of RLS cases will go away on their own with time or with minor lifestyle modifications. Restless legs syndrome (RLS) is a long-term condition characterized by a persistent need to move one's legs. The legs frequently have an uncomfortable sensation that improves with movement. In nature, this is typically described as aching, tingling, or crawling. The arms are occasionally affected as well. The feelings usually occur when you're sleeping, which makes it difficult to get a good night's sleep.

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RLS patients may experience daytime tiredness, low energy, irritability, and depression as a result of their sleep disturbances. Many people also twitch their limbs while sleeping.

Restless legs syndrome (RLS) can occur as a result of mental or physical problems, or as a side effect of certain medications. The severity of restless legs syndrome is determined by the frequency and severity of the symptoms, as well as how easily the symptoms may be eased by moving around and how much disruption they cause. It affects up to 1 in 10 people at some time during their life.

Restless legs syndrome affects some persons on a daily basis, while it affects others just rarely. Mild to severe symptoms can occur. Restless legs syndrome can be extremely distressing and interfere with a person's daily activities in extreme circumstances.

### *What is Restless Leg Syndrome?*

Restless legs syndrome (RLS), also known as Willis-Ekbom disease, is a movement disorder characterized by unpleasant sensations and involuntary leg movements during sleep.

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***Symptoms of Restless Leg Syndrome***

1. An urge or desire to move their legs, usually accompanied by uncomfortable sensations such as numbness, tingling, crawling, itching, aching, burning, cramping, or pain.
2. The urge to move or uncomfortable sensations begin or worsen during periods of rest or inactivity, such as when sitting watching television or traveling in a car or by airplane.
3. The urge to move or uncomfortable sensations are partially or totally relieved by activities such as stretching, walking, or exercising the affected muscles.
4. The urge to move or uncomfortable sensations are worse or occur solely in the evening or at night.
5. The urge to move or uncomfortable sensations are not solely due to another medical or behavioral problem (muscle pains, leg cramps, arthritis, habitual foot tapping).

***RLS is Categorized as Either Primary or Second Ary.***

1. Primary RLS is considered idiopathic or with no known cause. Primary RLS usually develops gradually before the age of 40–45 years and can last for months or even years. It's usually progressive and grows worse as you get older. Growing pains are frequently misinterpreted as RLS in youngsters.
2. Secondary RLS usually appears after the age of 40, and it may be present on a daily basis right away. It's most commonly linked to particular medical issues or the usage of certain medications.

## Causes

RLS affects about 5% to 10% of the population with mild symptoms. The rate of occurrence rises with age and is more common in women than in males.

There are two types of RLS, described as primary and secondary RLS. Primary RLS is also called idiopathic RLS. The primary type has no clear cause and tends to run in families.

***Secondary RLS Occurs in Association with Predisposing Conditions, Including***

- Iron deficiency
- End-stage kidney disease
- Diabetes
- Multiple sclerosis (MS)
- Parkinson's disease
- Peripheral neuropathy
- Varicose veins
- Thyroid disease
- Medication side effect

Pregnancy is associated with an increase in RLS symptoms. It is not clear why it occurs during pregnancy and the symptoms of RLS generally resolve after delivery.

***How RLS Develops***

RLS is caused by a variety of mechanisms. It's been linked to brain abnormalities as well as changes in leg feeling. According to experts, the illness can develop as a result of either of these issues, but it can also develop without either neuropathic pain or recognised brain alterations.

- Conditions that raise the risk of neuropathic pain, such as peripheral neuropathy and diabetes, might induce leg discomfort that is eased temporarily by movement.
- In RLS, the substantia nigra, a brain region, can be affected. The iron concentration of the substantia nigra may be low in iron-deficiency anaemia. This part of the brain is known to play a key role in controlling dopamine, a neurotransmitter, and mediating muscle activity. Several therapies for RLS operate by interacting with dopamine receptors in the brain to alleviate symptoms.

## Diagnosis

Although no particular diagnostics exist for RLS, non-specific laboratory testing are done to rule out other possible causes, including as vitamin deficiencies. To confirm the diagnosis, five symptoms are used

- A great need to move one's limbs, generally accompanied by unpleasant or unpleasant sensations.
- It begins or worsens during periods of idleness or relaxation.
- It gets better or goes away (at least briefly) with activity.
- It gets worse in the evening or at night.
- It is not caused by any medical or behavioural issue.

- Leg cramps, positional discomfort, local leg injury, arthritis, leg edoema, venous stasis, peripheral neuropathy, radiculopathy, habitual foot tapping/leg rocking, anxiety, myalgia, and drug-induced akathisia are the most prevalent disorders that should be

distinguished with RLS.

- Leg discomfort can also be caused by peripheral artery disease and arthritis, but it usually grows worse with movement.
- Myelopathy, myopathy, vascular or neurogenic claudication, hypotensive akathisia, orthostatic tremor, aching legs, and wiggling toes are some of the less common differential diagnoses.

### *Treatment*

The medication will depend on the individual but might include:

**Iron**: People with low iron levels may benefit from iron supplementation. This, in turn, may aid in the alleviation of symptoms. Iron supplements are available for purchase online.

**Alpha 2 agonists**: may aid with primary RLS, however they have little effect on periodic limb movement when sleeping.

**Painkillers:** Ibuprofen, a non-steroidal anti-inflammatory drug (NSAID), may help with mild symptoms. Ibuprofen is available for purchase online.

**Anticonvulsants:** These treat pain, muscle spasms, neuropathy, and daytime symptoms. Neurontin, or gabapentin, is a popular anticonvulsant.

**Benzodiazepines:** are sedative drugs that assist patients with RLS sleep through their symptoms, both severe and minor. Examples are Restoril, or temazepam, Xanax, or alprazolam, and Klonopin, or clonazepam.

**Dopaminergic agents:** These drugs increase the amount of dopamine in the brain, which is a neurotransmitter. They can help with the uncomfortable leg feelings that RLS causes. Dopaminergic drugs such as levodopa and carbidopa are often used.

**Dopamine agonists:** These cure unpleasant leg sensations by increasing dopamine levels in the brain. They may have negative consequences in older persons, while some people report that levodopa has more side effects.

**Opiates:** are pain relievers that can also help with RLS symptoms. When other drugs have failed, doctors may prescribe them. Low-dose opiates include codeine and propoxyphene, whereas high-dose opiates include oxycodone hydrochloride, methadone hydrochloride, and levorphanol tartrate.

RLS is sometimes treated with Parkinson's disease and epilepsy medicines, which can help to minimise uncontrollable movements.

### *Home remedies*

Lifestyle changes and common medications that may help alleviate RLS symptoms include:

- **Warm baths and massages:** can help to relax muscles and lessen the severity of symptoms.
- **Warm or cold packs:** Some people prefer warm, while others believe that alternating hot and cold packs is helpful.
- **Relaxation techniques:** Stress can make RLS worse, so exercises such as yoga, meditation, and tai chi may help.
- **Exercise:** using legs more can help alleviate symptoms. If the patient has a sedentary lifestyle, walking instead of driving, taking up a sport, or exercising the legs in a gym can help.

  Sleep hygiene for restless legs syndrome: Sleep hygiene is important, as tiredness makes symptoms worse.

### *Tips include*

- Sleeping in a cool, quiet bedroom.
- Going to bed at the same time every night, and getting up at the same time every morning.
- Reduce the amount of light you are exposed to for an hour before bed.
- Avoid stimulating drinks, such as caffeine or sugar.
- Avoiding or reducing alcohol consumption and tobacco.

Exercise and physical activity can help RLS, but it can also aggravate it. Most patients find moderate exercise helpful, but too much can make symptoms worse. Working out late in the evening may also be unhelpful.

## Conclusion

Physical activity and exercise can help RLS, but they can sometimes make it worse. Moderate activity is beneficial to the majority of patients, while excessive exercise might exacerbate symptoms. Exercising late at night might also be counterproductive.

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# Implantable Vascular Access Port insertion and Management

**Avadhesh Kumar Yadav**

**Abstract**

The device which is used to draw blood and some treatments including intravenous fluids, chemotherapy, blood transfusion and antibiotics therapy. The port should be placed under the skin preferably right side of chest. It is attached to a catheter (a thin, flexible tube) that is guided (threaded) into a large vein above the right side of the heart called the superior vena cava. The medication will be done by inserting a needle to draw blood or give fluids and other treatments. A port may stay in place for many weeks, months, or years. Also called chemo port (port-a-cath).

The main advantage of this vein-access device is that chemotherapy medications can be delivered directly into the port rather than a vein, eliminating the need for needle sticks. It needs to be inserted by specially trained professionals and prepare the patient to keep the chemo port safe with special care in order to prevent complication.

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## Introduction

The implantable subcutaneous venous access port or chemo port is a common procedure in patients requiring long-term venous access. Chemoport offers safe, smooth and cosmetically excellent venous access.

A chemotherapy port is a small device that is implanted under the patient's skin to allow easy access to your bloodstream[1]. A port may be used to draw blood samples for various diagnostic purpose and administer chemotherapy drugs. Blood and blood components can also be transfused whenever it required.

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In the absence of a port or a PICC line, every time we need to insert new intravenous line for the purpose of chemotherapy, intravenous Fluid infusion or a blood transfusion.

The use of implantable port has grown tremendously since their first use in 1981. Oncology patients were the first recipients of chemo port. The acceptance of these devices has increased rapidly and implantation of ports being more than 100000 each year.

These devices have designed by different manufactures companies in their own type of port, and More than fourteen manufactures companies making this device, still most are similar in design, function and application.

### *Design of Implanted Ports*

The implantable venous access device consists of the portal body and the catheter. The portal body is made of either stainless steel, titanium, polysulfone, or a combination therefore with an inner centre space

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called a reservoir. The three principle outside feature of the chemo port. are the base, the shoulder, and the barb[2].

A self-sealing, compressed silicone septum overlays the portal body[2]. The septum is designed for either top and/or side access[2]. This is done by achemo port. needle, Huber needle, or a needle with a deflective, non-coring tip[2].

## Indication

Indications for use of implantable ports over use of other central lines are;

- There is no external component to break.
- Patients with poor venous status, e.g. Cancer Patients, diabetic, and cystic fibrosis patients who have fragile veins which are difficult to access.
- Patients with need of long-term venous access.
- For the Patients who require total parenteral nutrition (TPN), vesicant drugs, chemotherapy and anti-biotics.
- Administration of pain medicines which are delivered by PCA or CADD pumps needs reliable venous access.
- Administration of blood products and need for blood draws are facilitated by use of achemo port.
- Patients with highly body image concerns, i.e. their body image is not threatened by external Intravenous catheters.
- Patients who requiremore mobility (young, active adults).

### *Advantages*

- Greater comfort
- Less delay
- Less risk of extravasation (leakage)
- Less risk of infection when bathing or swimming

### *Disadvantages*

- Surgical procedure needed to place the port.
- Can become infected.
- Can develop a clot in the catheter.
- Could stop working due to mechanical problem.
- Might limit some activities.
- Can leave a scar.

### *Contraindication*

- Chemo port should not be used when a known infection is present.
- A patient with too adequate or inadequate body tissue will present a challenge to the use of the chemo port.
- A chemo port should not be placed in severely neutropenic patients because of their lowered resistance to infection.
- Patients who has low platelet count are at risk for bleeding during and after operative procedures.

### *Chemo port insertion*

The most common site for insertion of Chemoport is the right Internal jugular vein. In case of right Internal jugular vein is not visible, or small in size, then the next choice was the left Internal jugular vein. The right subclavian vein or the right external jugular vein can be selected in case of thrombosed Internal jugular vein. Chemo port incretion performed in GA and LA. Technique of insertion should be routinely standard.

- Patient position is supine insert role towel under the shoulder to extend neck.
- Skin preparation was done with 10% povidone–iodine or chlorhexidine solution and sterile draping was used.
- Insertion into the entry vein was done with an ultrasound guidance using a 19-G puncture needle[3]. The angle of the needle should be away from the carotid artery. If the puncture was difficult, a micro puncture set with a 22-G puncture needle and a 0.018″ wire was used, and subsequently replaced with a 4-Fr introducer to facilitate transition to a 0.035″ system[3].
- Once the entry site was punctured, a guide wire was inserted and the proximal end was secured[3]. The distal end of the guide wire was ideally placed in the inferior vena cava (IVC)(3).
- Check the guide wire position in c-arm.
- The creation of the Chemoport pocket. The most common site for the pocket was at the delto-pectoral region, around 2.5 cm rom the clavicle[4].
- After the pocket was created, then take sutured in at least two sites to the underlying muscle.
- The silicone catheter was inserted using a trocar subcutaneously from the pocket to the entry site or vice versa.

- The tip was measured to reach the cavo–atrial junction.
- A peel-away sheath was inserted to facilitate the catheter insertion into the venous system. Catheter insertion is done by instructing patient to hold breath or inspiration and pinching of the peel-away sheath to avoid air embolism.
- The tip was then checked for kinks and optimal positioning by fluoroscopy.
- Aspiration of blood was done to check its function.
- Flushing with heparinized saline was done.
- The port was then closed in two layers using absorbable sutures. Sterile dressings were placed.
- A post-procedural chest radiograph was taken routinely.

### *Maintenance*

- If no I.V. fluids are infusing chemo port, flush with 10cc NS and 5cc heparin (100 unit/cc) once every 24 hours. Follow facility's policies and procedures.
- If I.V. fluids are infusing, avoid a very slow infusion rate (i.e. 5 ml/hr.) as this could contribute to the development of clots at the end of the internal catheter.
- Do not flush chemo port with heparin 500 units more often than once every eight hours. A thorough flush with NS is acceptable when frequent administration of I.V. medicines is required and the chemo port is heplocked.
- If the chemo port is not being used for infusion of medication or I.V. fluids, the port should be accessed once per month for a terminal flush with 10cc and 5cc heparin (100 units/cc).

  (NOTE: Heparin is used to keep blood from clotting in catheter. Once a clot forms, Heparin will not Dissolve the Clot.)

### *Nurse's responsibilities for I.P*

1. Maintaining the function of chemo port is a critically important task.
2. Access/ de-access chemo port.
3. Perform proper flushing technique.
4. Flush by creating a turbulent flow/ scrubbing action thereby clearing out residue.
5. Clamp tubing toward the end of the flushing action.
6. Withdrawal of blood.
   - Flush with 10cc NS and withdraw 3 cc to 5 cc of waste and discard.
   - Draw blood sample.
   - Flush with 10cc NS using proper flushing technique.
   - Continue I.V. fluids as ordered or, if heplocked, flush with 5cc heparin (100 unit/ml).
7. Troubleshoot problems such as cause of occlusions, tipped, edema around chemo port and catheter, and other situations encountered.
8. Assessment of skin integrity at the chemo port site.
9. Perform terminal flush once per month, when the port is not accessed.
10. Make patient familiar with design and function of port.

### *Documentation*

### *Accessing port documentation*

- Date and time accessing.
- Appearance of skin over and surrounding port.
- Whether blood return was positive or negative.

## Conclusion

Totally Implantable Vascular Access Port for chemotherapy at present are a safe enough, means for the administration of chemotherapy regiment or other substances, in view of the low number of complications observed.

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The methods section should include only information that was available at the time the plan or protocol for the study was written such as study approach, design, type of sample, sample size, sampling technique, setting of the study, description of data collection tools and methods; all information obtained during the conduct of the study belongs in the Results section.

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**Standard journal article**

[1] Flink H, Tegelberg Å, Thörn M, Lagerlöf F. Effect of oral iron supplementation on unstimulated salivary flow rate: A randomized, double-blind, placebo-controlled trial. J Oral Pathol Med 2006; 35: 540-7.

[2] Twetman S, Axelsson S, Dahlgren H, Holm AK, Källestål C, Lagerlöf F, et al. Caries-preventive effect of fluoride toothpaste: A systematic review. Acta Odontol Scand 2003; 61: 347-55.

**Article in supplement or special issue**

[3] Fleischer W, Reimer K. Povidone iodine antisepsis. State of the art. Dermatology 1997; 195 Suppl 2: 3-9.

**Corporate (collective) author**

[4] American Academy of Periodontology. Sonic and ultrasonic scalers in periodontics. J Periodontol 2000; 71: 1792-801.

**Unpublished article**

[5] Garoushi S, Lassila LV, Tezvergil A, Vallittu PK. Static and fatigue compression test for particulate filler composite resin with fiber-reinforced composite substructure. Dent Mater 2006.

**Personal author(s)**

[6] Hosmer D, Lemeshow S. Applied logistic regression, 2nd edn. New York: Wiley-Interscience; 2000.

**Chapter in book**

[7] Nauntofte B, Tenovuo J, Lagerlöf F. Secretion and composition of saliva. In: Fejerskov O,

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Kidd EAM, editors. Dental caries: The disease and its clinical management. Oxford: Blackwell Munksgaard; 2003. p. 7-27.

**No author given**

[8] World Health Organization. Oral health surveys - basic methods, 4th edn. Geneva: World Health Organization; 1997.

**Reference from electronic media**

[9] National Statistics Online—Trends in suicide by method in England and Wales, 1979-2001. www.statistics.gov.uk/downloads/theme_health/HSQ 20.pdf (accessed Jan 24, 2005): 7-18. Only verified references against the original documents should be cited. Authors are responsible for the accuracy and completeness of their references and for correct text citation. The number of reference should be kept limited to 20 in case of major communications and 10 for short communications.

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