

[I survived cancer, but will I survive the transition back to school?](#)

Presented By: Anne Mauck, CPNP, CPON
Pediatric Hematology Oncology
Children's Hospital of Richmond at VCU

In your booklet, in the back, there is a whole page about the cancer statistics, significant for Southwest Virginia. Approximately 20 to 30 new patients are diagnosed here in this area, every year. Approximately one in 330 children will be diagnosed with cancer in this area before the age of 20. The place where they get treated is Carilion Clinic so that is probably where most of the kids have been treated that you guys see in your specific counties. Then if you look, there's also a whole big page with contact information for you about the PT clinic at Carilion so I think you might want to know that's in there if you want it.

The first person I'm going to talk about, these were two patients that have described to me and coming back to clinic, that returning to high school was maybe worse than going through cancer itself. The first patient is a 17 year-old who was diagnosed with stage 4B Hodgkin's Lymphoma, about a year ago. She had peripheral neuropathy in her feet after finishing radiation, right around the time of returning to school recently this fall. She's an 11th grader. She was an avid lacrosse player and what I mean by that is she was amazing. She had been playing lacrosse with these same girls on her team for years. She played year round lacrosse and had been with the same group, had a lot of friends and when she returned to school, because of her peripheral neuropathy, she was in braces. She wasn't going to be able to play lacrosse and her lacrosse friends, I'm not going to say that they dropped her but I just don't think they really knew how to interact with her and so she was kind of left feeling like she didn't have any friends. She didn't see her friends on the lacrosse team. She went in the same classes. She migrated to a new friend group but she continued to face challenges because of some of the educational problems that she had, because of her chemotherapy.

She had to miss school three times a week in the afternoons for physical therapy appointments and so that sort of kept her from making a lot of new friends. She struggles with short term memory, slower processing speed, and she has anxiety that predated her cancer diagnosis and so her anxiety was really revved up having to come back to school, losing her friend group, not being able to play lacrosse. She constantly tells me or told me that she has to advocate with her teachers and remind them about her 504, which she didn't have previous to her cancer diagnosis and navigating the crowded hallways was especially difficult for her with her braces so even though they had tried to get her to be able to leave class early, it didn't always happen. People were pushing and shoving and made it really hard for her.

That being said, right around now, she said her anxiety is better, oh, and that's when she said coming back to school was harder for me than actually going through the Hodgkin's disease treatment. Her anxiety is improved. We've gotten NP testing, have further supported her accommodations. She's now back to playing lacrosse. She's got some modified practices, and things are going a lot better for her, but that's just a really good example of how a 17 year-old faced return to school with some of the challenges that she had.

The next patient I'm going to tell you about is someone who was diagnosed with medulloblastoma when she was a young girl. She returned to school in elementary and things were okay. She had a lot of the global effects of medulloblastoma, which is brain cancer. She had very significant cognitive effects and had an IEP, was mainstreamed in

classes except pulled out for resources for reading and math. She has five motor skill deficits, gross motor skill deficits, hearing loss, she wears glasses and her speech has been affected because of her severe hearing impairment. She did well though in elementary school, and was participating in sports, and the kids seem to really like her and enjoy her, and she had friends.

When she got into middle school, because she was so much less mature than some of the girls at her class, started having strained friendships and by the time she got to high school and when I saw her in the fall, she said no one sits with her at lunch. She can't play sports because she doesn't have the coordination, wasn't lucky enough to get a manager position, which is what I'd hoped would have happened, that did not happen. She's feeling very isolated. She only has friends in her resource classes. She said kids call her names; they call her stupid. They try and trip her up in the hallway. I mean this really made me want to cry, and I think what I want to really leave with you, is with someone like this, this girl has the heart the size of Montana. I think we really need to try very hard to look at children who are different and we need to celebrate their differences and we need to find positive ways to make it better.

It breaks my heart to think about this and I know we are better than that so we've got to practice kindness and we have to find ways to make it an easier road for some of our significantly impacted young adults or children. Okay, so there's good news. With childhood cancer survivorship. As Dr. Dunsmore said approximately 15,000 or 16,000 children and young adults, ages zero to 19, will be diagnosed with cancer or were diagnosed with cancer in 2018. 88% or close to 90% survive. In 1975, we only had about 50% surviving so as you've heard, our diagnosis and survivorship rates have increased. Each year, the survival rate of children and adolescents increases by approximately 1% so that means that we will continue to have more and more childhood cancer survivors.

What is survivorship? What we claim survivorship is you have to be five years from diagnosis of your cancer and two years off treatment, and when both of those things intersect, you are then considered a childhood cancer survivor. There's some bad news. There is a cost to cure and you heard some of that from Dr. Dunsmore. All of the areas that are on this slide are where significant costs can occur. You can have physical, psychosocial, neurocognitive, endocrine, reproductive and second malignancy risks. Virtually every system in your body can be affected and we're going to talk about some of those issues today, but there's even more bad news and as she said, two thirds of people who survived cancer, suffer devastating late effects, second malignancies, infertility are just some of the things that can occur. The incidence of late effects increases with age and if you think about it, it's because we don't treat our bodies as well as we age and there's environmental impacts that are important, and sometimes late effects could take a decade or more to be visible. Sometimes they are visible as soon as treatment ends, but not always.

So really, the diagnosis of cancer is devastating. The childhood cancer survivor study is made of two levels of childhood cancer survivor studies. There's the 1970 to 1986 group, and that's really the much older patients who have survived cancer, and then because we've really changed our treatments since the 90s, we have a group of childhood cancer survivors from 1987 to 1999. Actually, I think we're inclusive of 2003 by now, but what these are, are long term retrospective cohort studies that have helped establish some real decision making for us as to how we will treat children to avoid late effects. Some of the findings that we found is that adolescent childhood cancer survivors have higher levels of social and behavioral problems and what we see are anxiety, depression, attention deficit, and antisocial behaviors, and the quality of life is similar in most groups, but it's lower in certain cases and this is really important because the people who are at higher risk are females,

patients who have had bone cancer or brain cancer, patients who are older at diagnosis, patients who have low self-esteem and suffer from fatigue.

I will tell you that 99% of patients who have been diagnosed with cancer will talk to you about fatigue issues. Then the demographics that stand out are lower socio economic status and Hispanic culture. Academics and beyond. Childhood cancer survivors are at a higher risk for academic problems and adverse outcomes. Unemployment is 25% higher in childhood cancer survivors with brain tumors, who had radiation, those that were treated at a younger age and those with chronic medical conditions. Actually, survivors of brain tumors tend to live with their parents more frequently. They have difficulty developing intimate relationships. The numbers for them to remain single are much higher. They tend to have difficulty getting jobs so this is a population that we really need to work strongly with in school to move them forward so that they can become independent adults.

Survivors face more challenges with relationships and siblings who are older at diagnosis have higher levels of anxiety and/or are heavily treated. These are things that are important to remember when you're trying to get a child back to school and have them be successful. So who, what and how? Children and young adult cancer survivors are not going to be the same. The family's not going to be the same. If you ask the family members or a sibling, they'll tell you, well, we have a new normal, but we're not going to be able to be what we were before our sister or our brother was diagnosed. Friends sometimes move on, a lot of times they do move on, sometimes they come back but this is another area where children have to suffer. They may or may not have late effects and as I've sort of mentioned, they're trying to navigate into this new normal. It's important to think about what is normal. What's normal for a child?

Growing and developing. Children go to school, they don't work, they don't stay at home, they go to school so if you're having cancer treatment and you're not going to school, already, you're not having what we would consider a normal life. Learning and doing is normal. Socializing. Learning how to make friends, learning how to keep friends, learning how to be in an environment, becoming independent, feeling and emoting, and feeling and emoting in a positive and socially acceptable manner is important and then making mistakes, because that's how we learn. We make mistakes and we learn from our mistakes. That's normal. So a new normal, this child or this adolescent is going to come back to school and they're going to be compared to the normal children. The child may compare himself or herself to how he was or how she was before she was diagnosed.

I had one patient who, unfortunately passed away was one of the first patients that I ever met, and she was a feisty 16 year-old when she was diagnosed with very high risk acute lymphoblastic leukemia. She was on track to be the valedictorian at her high school and she went through treatment and relapse pretty early on, and we got her back into remission and then she had a central nervous system relapse and she would come to clinic and say, she wanted to go to school so we let her go to school as much as possible, but she would say, "I'm sitting in class, and I am telling you, I can't keep the math in my head. The teacher says something and it goes in one ear and right out the other. I was the smartest kid in my class and now I feel like I'm a failure. I can't think like I used to, I'm not going to take my medicine anymore." So she stopped taking her methotrexate and 6-MP, and you know she was just always fighting us, but it was really hard for her to see herself as something that she hadn't anticipated. Children may feel isolated and they may have fears of the next step and the next step is coming back to school. Some of the children who have fears of the next step will engage in risky behaviors, drinking, smoking, pot, vaping, whatever it is, and those are things that we have to kind of deal with.

The transition back to school. Why is it important? Because it's one way for us to normalize a very difficult experience. We want our survivors to master educational goals and social skills. We know that if they don't master the educational goals or if they don't have improved social skills, that their quality of life is going to go down and we're going to have issues. Childhood cancer survivors have a range of problems that require ongoing support and unmet needs, ultimately will result in unfavorable outcomes. Here we have children that have survived cancer, now comes the hard part, returning to school.

What I'm going to talk about first, before I kind of go into late effects or some of the acute effects of cancer, these are for children who would be returning back to school while they're on treatment. Children who are in treatment may look and act differently from their peers. If I show you this picture, everyone in this room would probably be able to imagine that this child is going through cancer treatment. I mean, it's pretty evident and if I showed you this picture of this high school student, you might surmise that she has recently had some sort of treatment. Now, some children would come back to school without a wig. A lot of our patients don't wear wigs, but I don't know that they would go to school that way. They may come to clinic in the wig, and then they take the wig off and put it on their IV pole, and go around with their bald head, but I don't know how they would feel at school.

Some of the common side effects that we see with children who are acutely in treatment and coming back to school are physical changes. They might be wearing braces because they have a peripheral neuropathy or if they've had a limb salvage or an amputation, there might be a missing limb or there might be a prosthesis, they might have crutches, they could have weight loss or gain. If they're on steroids, often they'll have a very round face. A lot of the children will have fatigue and low stamina, and it's just because they are deconditioned. They really haven't been able to exercise or get out there like their peers. Cloudy thinking, and cloudy thinking can relate to just about anything, a lot of patients will call it chemo brain, but they cannot hold thoughts in their brain for very long or they'll be able to hold it long enough to write down the first third of what the thought was and then the teacher's on to the next thought, and they've missed the last two thirds of whatever thought they had.

GI effects, and these are things that can promote a lot of anxiety. If you're suffering from nausea or vomiting, or you have explosive diarrhea, and you don't have any warning of it, that's going to make you really nervous about going back to school. Fever, infection, bruising, bleeding, mood swings from steroids, and glasses or hearing aids, all of these are common side effects that you might see in children who are being treated for cancer. Psycho socially, our patients will tell us that they might feel isolated, they don't want to be different, but they know they're different. They're fearful of return to school or being sad or grieving. They feel guilty that they've survived and maybe one of their friends didn't survive, perhaps they're angry, versus others have a positive self-outlook. They've got increased maturity, they have a wide view of the lived experience and they're really able to internalize and look towards the future. Two very different sides of the coin.

You've got to remember though, everyone is different and you have to be flexible when you're looking at children coming back to school, and you need to assess where that person is, because there's no normal response to cancer and its treatment. Everyone's going to transition back to school in a very different way and you need to have an individualized approach to how you deal with it. I love this picture because on the right or actually on your left, Noah is a cancer patient and I mean, he looks like a positive little guy but you can tell he's a cancer patient, but on the right, if this little boy came into your classroom or came into your nurse's office or came into the counseling office, you wouldn't know that he had

had cancer unless you had records that told you that. Once they're off treatment, they're not necessarily going to look different from anyone else.

Now we're going to talk a little bit about late effects. Late effects or side effects or consequences of cancer treatment that are not necessarily there in the acute phase, sometimes they can take decades or longer to be visible, sometimes these are adverse effects that you do see during treatment and that don't resolve after treatment has ended so a lot of times, like let's say with peripheral neuropathy. Once we take away the drug that causes the peripheral neuropathy, a lot of patients will have decreased neuropathy and then it can really, their nerves can get back to normal. Some patients have neuropathy that continues after the acute phase of treatment and so it's important to kind of know that would then be a late effect if treatment had ended and your patient still has a neuropathy.

You can have physical or psychosocial effects and oftentimes, we're going to note late effects during periods of growth or maturation so that's an important time where we really want to be right on top of our survivors to kind of see what's going on. Late effects can be physical, psychosocial, emotional, and they can be existing or they can have a potential risk for something. Our patients know, once they're off treatment, they get a treatment summary and we tell them, well, this is what you have and this, or maybe you don't have any now but you're at risk for this, this, this and this, so our patients know what they're at risk for and that can also promote a little bit of anxiety. Influencing factors for late effects include the age of diagnosis. In general, the younger the age that you're diagnosed, the increase the risk for late effects because you have that much longer to live.

Underlying genetics, as Dr. Dunsmore talked about, if you have some genetics in your family history like a Li-Fraumeni syndrome or, in other words, you have the loss of the p53 gene, which is a tumor suppressor gene, then that's going to be something very important to know. The type of cancer and the location of the disease so in general, most pediatric cancers are metastatic, just because that's how it is. Think of leukemia, it goes everywhere and it's not really important for prognosis for children, but it's important for you to know that it's been everywhere. It's important to know how much treatment they got and usually, the higher the stage, the more treatment you're going to get. Then the type of treatment, chemo, surgery, radiation, transplant, bio therapy, and as she mentioned, CAR-T therapy for our high risk leukemia patients.

More influencing factors, if you had complications acutely during therapy, that's important. The type of psychosocial support you had, actually how your family views your diagnosis, are they protecting you or are they helping you to try and be independent? The health related behaviors that you yourself are doing. Risky behaviors happen in adolescents and so you really have to sit on your adolescent survivors and make sure, and they will also not tell you the truth, but hopefully you can read between the lines. New stages of development, as I've mentioned, puberty, body changes, and then independence versus overprotection, that is often going to affect how the person views his role in his own health.

Potential late effects. These are the areas where you can have late effects, neurocognitive, auditory, visual, cardiac, pulmonary, hepatic, endocrine or reproductive, skin, GI, musculoskeletal, second malignancy and psychosocial, and I'm going to go over each of these individually.

Neurocognitive. The folks that have the highest risk for neurocognitive effects are brain tumor survivors, leukemia survivors, lymphoma survivors, and then anyone that's had a head and neck cancer, particularly if they were going to get radiation so a Rhabdomyolysis

of any kind of muscle inside your brain or nasopharyngeal cancer, children who are less than three at treatment, and why do you think that is?

Because you're growing and children who have missed opportunities for learning so this is really important when you think about patients who have had a Wilms tumor. Children with Wilms tumor are diagnosed between the ages of two and four, they get between six months to a year of treatment, plus or minus radiation, if they have mets to their lungs, they'll get ready radiation to their lung and to the tumor bed, if they are a higher stage, but there are no chemotherapeutic agents that cross the blood brain barrier and would cause cognitive effects. I mean truthfully, but Alma and I have noticed our Wilms tumor survivors, every single one of them, without fail, has some cognitive effect of therapy and so we are thinking about it, when we would do their neuropsych testing or when they would return to school in elementary school, they would just not do very well.

And so we were thinking is this about missed opportunities? These children are treated when they're very young, their brain is developing and maybe this is what it is. It's not that we are giving them a specific medicine that is crossing the blood brain barrier changing what's happening up there. It's just that they're missing opportunities to learn and sometimes what is taught is not really what you're seeing, and you have to kind of make sense of it so missed opportunities, I think is a real problem for neurocognitive development. It's a problem.

Brain tumor patients get treated with surgery, chemo, radiation and sometimes autologous cell transplant. That's a lot of treatment. Most patients are younger, 12 and under. The treatment can cause specific changes in the brain so radiation and certain chemotherapeutic agents; they've got to cross the blood brain barrier because they're treating the brain, they're going to cause white matter changes and what happens when you have white matter changes? The place where you're most affected or how you're thinking is most affected, is in your ability to conceptualize, your ability to not respond to things that are over here bothering you so it's like you're losing the ability to executive functioning.

Number one, inhibition. You have decreased inhibition so suddenly, where you used to not get distracted, now, you're totally distracted. The second thing is your working memory is completely altered. You used to have a very good working memory and now you have no working memory. And the third thing that happens is your cognitive flexibility changes so you're not able to move from task to task. Does this sound like anything? Like if I were, ADD. And so it's amazing how it's not ADD but it's ADD like. Treatment can cause other issues for patients with brain tumors. You can have visual issues, you can have high frequency hearing loss, motor issues, a lot of them will have fine and gross motor deficits, and coordination issues.

Global issues involving cognition, sensory and motor systems, and the social development can be affected. These children will miss important social cues. If you're sitting at a table and the person to the left tells a joke, and four out of the five children will laugh at the time that they should and then the fifth child happens to be a brain tumor survivor. A good 15 seconds might go by and then suddenly, that child's going to giggle because it took him that long to get it and that's a hard thing when you're in class, to be the child that it takes a little longer to understand. Finally, they're immature for their age. Neurocognitive for leukemia and lymphoma is a little bit the same, but it's high dose methotrexate that crosses the blood brain barrier or methotrexate and cytarabine that are put into the intrathecal medicine in the LP, and leukemia and Non-Hodgkin lymphoma, they also get intrathecal, and then cranial radiation for our T cell ALL patients.

80% of all leukemia survivors are going to have white matter changes. Now we can see the white matter changes if we were to serially MRI every ALL patient, we would see that. I would say that maybe 60% of patients with ALL are going to have bonafide neurocognitive effects so it's important for us to test these children, give them a neuropsych test to make sure that we're capturing if they're having problems. This is why this slide is blank, I'm not going to talk much about what the neurocognitive effects are, because that's really going to be Alma's talk, but some of the things that we see are slower thinking, word finding issues, reading fluency and comprehension problems, math computation is a huge problem, short term memory deficits, and decrease processing speeds. I would say generally, any child with leukemia is going to have one or all of those.

Then for auditory, we have high frequency hearing loss. If you think about that, that's going to be at the hertz where female voices are heard, and how many teachers in the school system are female? Most of them, I mean there are some male teachers, but most of us are talking up here and not way down here. Communication disorders, these patients may need speech therapy and if they have communication disorders, isolation and interaction with others can be impaired. Visual issues, they're at risk for early cataracts. Patients that have had a brain tumor removed, can sometimes have double vision and their vision can be double like this way, like I'm seeing two of you or it can be this way, so I'm seeing one of you on top of one of you, it's important to know or ask if they've had a brain tumor, are they having double vision and which way their vision is going? Those children would need preferential seating or maybe a scribe, and if they can't really see well to read, maybe we could give them oral exams.

Cardiac effects. We thought there was going to be more cardiac damage actually than there has been, and usually we see it later so it's not really that big of a deal for return to school, but there can be valve damage, narrowing of blood vessels, hyperlipidemia. A lot of our patients will become obese. They have exercise restrictions so they might not be able to participate in PE with the others and again, I mentioned before, they can be de-conditioned because they just haven't been exercising the way that other kids have been. Pulmonary effects, we could see pulmonary fibrosis, restrictive or obstructive lung disease from bleomycin or radiation for patients that have had Wilms tumor. Again, they would need exercise restrictions or if they have really stiff lungs and can't do anything, they might need a disease plan because you wouldn't want a child in that situation to get a bad viral illness.

GI effects, as I mentioned earlier, can cause a great deal of anxiety: diarrhea, constipation, nausea, vomiting. A bathroom pass is critical or a nurse pass, the child needs to be able to raise the blue ticket, nobody has to see it but the teacher and then they can slide out the door. Endocrine effects, thyroid dysfunction, growth hormone deficiency, fatigue, and having a place to nap or rest. I'll tell you this past, I think it was in December, I saw a little third grader and the key word in that sentence is little. He is about the size of a first grader in height so he's going to endocrine to see if he has a growth hormone deficiency because he's fallen off on his height but he told me in tears that when he gets on the bus, the third graders say, "You have to sit back there where the first graders sit because you're nothing but a first grader." and I mean he's the cutest, funniest little kid but this is causing him a great deal of anxiety and self-esteem issues. He's not doing well in school and doesn't want to go to school so he's going through counseling now to work through it.

Skin effects. We can have permanent hair loss from patients that have had surgery or radiation to the skull. They need to be able to wear a hat or a wig and not be asked to remove it. We've had stories where principals have pulled off someone's hat, going through the hall only to uncover a very bald head on a young lady, which caused her a great deal of anxiety, and then there can be skin changes, particularly in our patients who have darker

colored skin. Some of the chemotherapies can cause moles and dark sort of spots, particularly on your face. It's like melasma but it's really related to the chemotherapy and those often don't fade, and so girls particularly can have feelings of anxiety related to how they look when they see themselves in the mirror.

Kidney and bladder, our patients with Wilms tumor have single kidneys, so sports are an issue depending on if they want to play football. They should wear a pad if their mom's going to let them do that. We don't really limit any other sports, but they need to drink water all the time and they need to know if they have a fever, we've got to check that out and then bladder fibrosis can cause urinary frequency and urgency so again, that bathroom pass is really important.

Musculoskeletal. Our patients who've had radiation to the back or have had spinal tumors are at risk for scoliosis. Anyone who's had an amputation may or may not choose to have or may not have a prosthesis. We have a 37 year-old who had a Rhabdomyolysis and had a forequarter amputation of her right shoulder and arm and when she got her prosthesis, it strapped under where her arm would have been and then over and around and she really couldn't walk with it. It was very heavy and so she gave it up. I don't even think she wore it for a couple of months and she's lived her whole life now with this forequarter amputation, which she's okay with but when people first see her, because there's no shoulder here, it's disfiguring.

They can have decreased bone growth, leg length discrepancy, foot drop, which is the inability to dorsiflex your ankles, and you tend to walk really flat footed. Instead of being able to do this, so running is really hard if you're walking flatfooted. You're not going to go very far. If you're trying to climb stairs, you're likely going to fall and then avascular necrosis of the femoral heads. Usually those kids are going to end up having a hip replacement so they're going to return to school with crutches, so you've got to think about how are they going to get through the halls, how are they going to be able to manage a book bag, and you might need to get someone to help them with books.

Some musculoskeletal interventions, exercise intolerance or just getting to the next class, they need assistance. Their body image could give them low self-esteem if they don't like what they see in the mirror and fine motor skill deficits. We've had a lot of children who have had to change from right handed to left handedness, for whatever reason and if they're in class with fifth graders who have been writing with their left hand all this time, and they're now writing with their left hand, they're going to be a lot slower at it so those kinds of considerations need to be thought about and then anyone who's had a limb salvage is likely going to have future surgery so you need to be aware of that too.

Finally, the psychosocial effects. Some of the negative effects, fear and anxiety, isolation, decreased coping, PTSD, depression, and really parental support, relate sometimes to how a child internalizes and then deals with their diagnosis. On the right side, we have more of the positive coping strategies, sense of self, finding benefit in the treatment, the diagnosis and treatment, kind of internalizing that and looking forward. Confidence and self-esteem are sort of outgrowths of that. Two very different ways of handling your diagnosis and finally, we're going to be looking at back to school so this is a little cartoon or a picture of a young man who is sitting, if you can tell, he's sitting on rocks on the side of a trail and you can very evidently see that he's had a limb salvage. He probably had an osteo of a tibia fibula so they gave him a prosthesis that probably connects up above in his thigh and he looks like he's happy, he looks adjusted. He's on a trail so that kind of gives you some idea of what kind of a place he's coming from.

School reentry, why is this important? Why are we harping on our patients coming back to school? Because we want them to normalize this very difficult experience. We want them to master the educational goals and social skills. We want them to get a degree, we want them to get a job, we want them to be productive. We want them to have a life that they should have had if they didn't take the detour of cancer diagnosis and we know that a smooth transition is going to positively impact the quality of life that these children are going to have, that their family is going to have and hopefully that they will have as a young adult. When do we return to school? We think that it's important to return to school as soon as possible. When is that? If that's during treatment, and they can do it, great, make it happen but it's not the same for everyone so we're going to negotiate this among the child, the parent, the medical team, and our educational consultant, Alma Morgan, who is the one person on that whole team, besides the child, who is probably the most important person. She really is able to assess what the child needs, and she knows all the school. She goes to over 100 visits every year so she's going to be able to really be a critical piece of helping that child get back to school and negotiating with the school district as to what's the safest, best way to make it happen.

But it's different for everyone so just because one of your children came back this way doesn't mean that that's going to be easy for the next child. We have to think about what we're trying to accomplish. Sometimes, if we're returning a child to school that doesn't have a good prognosis to live, we have a very different reason for them coming back than for someone who is a survivor and is coming back with goals and a future and it's important, both of those are very good reasons to come back to school but it's important to kind of know what your short term and your long term goals are. You need to know what the child can handle. Again, the short and long term goals are important. You need to anticipate absences. If they're coming back on treatment, they're going to be going back to the medical team and it may be more frequently than you think but if they're off treatment, they're probably still coming back at least once a month, or maybe more than that but once a month, every other month. We're going to be seeing them on a regular basis.

You have to think about physical limitations. You have to think about English as a second language. A lot of times we really don't pay attention to that and these children can well in school, and then they go home, and there's no one there to help them with their homework, because they're speaking Spanish as their primary language at home and we have a very large group of Hispanic patients in our area. We're very, very focused in on in Richmond. We need to have a communicable disease plan if they're just off treatment, because their immunizations are not going to be up to date and particularly if they're younger, they're not going to have had probably the varicella vaccine and so if chicken pox outbreak occurs in your school district, you need to know which parents you're going to have to call and say, "Please don't send your child to school.", and you need to know whether they need an IEP or 504 before so hopefully, if we haven't done the neuro psych testing, we're going to do the neuro psych testing so we can have a really good idea of how the child learns.

As far as further considerations, you want to start slowly and adjust as you need to. The most important part of all of this is communication, and it's not just between the teacher and the child or the nurse and the child. It's the child, the school district, it's Alma, it's us, it's everybody. We have to remember that we've got to keep those lines of communication open. We involve Alma in virtually every transition back to school because it's just important that we get it right the first time and then I really want to say try not to label.

And we've got to just be kind, celebrate the differences and make them special in a way that's not negative. Best transition, again, communication, communication and communication. You guys are really positioned in a place for advocacy, for the child, for the

family, for our team, for the communication, to be on that education team to really keep the school district informed as to what the needs are of this population and so I say go for it. If you can be on the educational team, that would be great.