LEARNING OBJECTIVES

1. Understand the rationale for offering surgery, chemotherapy and/or radiotherapy for patients with colorectal cancer.
2. Know the possible side-effects that patients may experience in the first 12 weeks after surgery.

Nurses play an important role in preparing patients for discharge from hospital following surgery for colorectal cancer.

The time available to plan and provide good discharge care has reduced, since inpatient stays following such surgery are shorter thanks to laparoscopic surgery and the Enhanced Recovery Programme (ERP). Therefore it is necessary to be more proactive in assessing the nursing care that patients might need.

Discharge care involves monitoring, supporting and promoting patients’ post-operative recovery and preparing them for what to expect after colorectal cancer surgery. Patients’ readiness to self-care and their confidence and ability to do so are equally as important as their medical fitness for discharge.

COLORECTAL SURGERY

Many people diagnosed with colorectal cancer will be treated by surgery since it offers the best chance of cure.

Most patients are given around two weeks to prepare for their operation, although approximately 15% will be operated on following emergency presentation.

If a curative procedure is not achievable, surgery may still be offered to manage the bowel. Patients might need.

Colorectal surgery involves removal of a section of bowel plus a clear margin of adjacent tissue (including lymph nodes and blood vessels) can help them to understand the side-effects they may experience afterwards.

In most cases, patients stay in hospital for an average of 5–7 days. Recovery times are shorter for those treated with laparoscopy or under the ERP.

The ERP is an evidence-based and multimodal approach that involves the whole multidisciplinary team in achieving rapid rehabilitation (King et al, 2006). Critical to its success is informing patients what will be expected of them during their recovery, in particular early post-operative feeding and walking. This approach also highlights how well patients respond when they are treated as equal partners in care.

Side-effects of surgery

To prepare patients for the weeks and months after discharge, they should be offered both oral and written information about possible post-operative side-effects.

Common side-effects include: abdominal pain; infection (wound, urinary tract and/or chest); loss of energy and appetite; and change in bowel function. Of these, bowel dysfunction (frequency and urgency of bowel motions) is perhaps the most distressing – particularly for those recovering from a rectal resection without stoma formation (Camilleri-Brennan and Steele, 1998).

These patients should be warned about ‘anterior resection syndrome’, a specific cluster of symptoms consisting of frequency, urgency, stool fragmentation and incontinence of faeces (Desnou and Faithfull, 2005). In addition to significant changes in bowel function, rectal resections can also cause sexual and urinary dysfunction (Jephcott et al, 2004).

The incidence of these surgical complications varies and individual outcomes will depend on surgical success, responses to the trauma and general health.

While patients should be warned about these possible complications before surgery, further explanation may be needed before discharge.

Nurses can reassure patients that for most people, side-effects lessen and functional ability increases over time with appropriate management and support. Patients can be told to expect the greatest improvement in health over the first 12 weeks after surgery. However, if symptoms persist or are troublesome, they must be advised to contact their specialist nurse and/or surgical...
team. For some, it may take up to six months for the surgical side-effects to reach a tolerable level (Ulander et al, 1997).

Other effects of surgery
Surgery involving temporary or permanent stoma formation affects lifestyle in a number of ways, such as participation in sports and leisure, delay in returning to work, concerns about diet and clothing and restrictions in sexual function.

It is not surprising that people with stomas report higher levels of psychological distress than those without. Stoma therapists are skilled in helping patients master the practical issues as well as facilitating adaptation to changes in body image, function and lifestyle. Clear guidelines on rehabilitation after ostomy surgery are available (Erwin-Toth, 2006).

Patients should be informed that initially they may feel relieved and even excited at the prospect of discharge but that once home they may become apprehensive, frustrated and even despondent. Over time, other emotional and social difficulties may be experienced such as financial hardship, changes in self-concept and body image, social isolation and a difficulty in re-establishing intimacy. There may also be underlying fears about the potential curability of their cancer, creating anxieties about the future.

Patients recovering from a palliative surgical procedure may experience a greater range of emotional, physical, social and spiritual effects. More physical limitation, emotional distress and a greater need for adaptation are likely. A slower recovery and a greater need for community support after discharge should be anticipated.

Follow-up
Patients prefer to leave hospital aware of the local follow-up arrangements and with a date for their first appointment.

The first outpatient appointment should be arranged for 2–6 weeks after discharge, depending on local policy. At this appointment, the surgical team will review recovery, check for any side-effects and address concerns. The team is also likely to discuss histology results (following the microscopic examination of the resected bowel) and may introduce (or refer to) an oncologist to discuss further treatment.

Some patients find it helpful to prepare written questions to ask at this consultation.

As well as offering patients support and review, surgical follow-up is a means of detecting recurrent disease, 80% of which occurs in the first two years.

The colorectal cancer nurse specialist (CNS) is an integral member of the colorectal multidisciplinary team and may provide the programme of follow-up care (Cardy and Taylor, 2003). In addition, colorectal CNSs offer patients tailored and accessible support from diagnosis through to treatment and after discharge (Knowles et al, 2007). This allows patients to discuss concerns and obtain information.

Further treatment
Patients are likely to be anxious about surgical outcomes and the possibility of needing further cancer treatment.

While waiting for the histology report, the surgeon can usually provide some indication of the surgery’s success based on both the pre-operative staging investigations and the macroscopic findings at surgery. Patients seeking information can be encouraged to ask for this during the surgical ward round.

The histological stage of the bowel cancer is classified using the TNM staging system and/or by Dukes’ classification system. The TNM system assesses the extent of direct spread of the tumour (T), the presence of lymph node metastases (N) and the presence of distant metastases (M). Dukes’ staging system was designed specifically for colorectal cancer, with four stages designated as A, B, C1 and C2, in order of worsening prognosis. See Fig 1 in Portfolio Pages at nursingtimes.net for details.

Adjuvant chemotherapy may be offered before, or more usually after, surgery to decrease risk of cancer recurrence. Radiotherapy will be advised if there is a high risk of locally recurrent rectal cancer, and will be given before or after surgery. It can also be used to palliate rectal cancer.

Patients whose disease cannot be cured will be offered further treatment if they are willing and well enough. This will usually be chemotherapy, plus the possibility of further surgery if there are operable metastases. Treatments should be carefully discussed with each patient, taking into account their individual preferences and level of fitness, staging of disease and previous treatments.

KEY REFERENCES


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Part 2, to be published in next week’s issue, explores assessment, planning, technical care and practical advice when preparing patients for discharge.