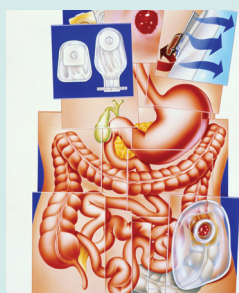


Irrigation Practices in Long-Term Survivors of Colorectal Cancer With Colostomies

Marcia Grant, RN, DNSc, FAAN, Carmit K. McMullen, PhD, Andrea Altschuler, PhD, Mark C. Hornbrook, PhD, Lisa J. Herrinton, PhD, Christopher S. Wendel, MS, Carol M. Baldwin, PhD, RN, CHTP, AHN-BC, and Robert S. Krouse, MD, FACS



© John Bavosi/Photo Researchers, Inc.

For some patients diagnosed with rectal cancer, surgery will involve the creation of a temporary or permanent ostomy. When the colostomy is located in the sigmoid or descending colon, regulation of fecal output can occur through irrigation, a procedure that involves instilling fluid into the bowel to flush out gas and fecal material. When successfully used, irrigation can prevent fecal output between irrigations, providing some control over colostomy output. The purpose of this article is to describe participants of a large, multisite, multi-investigator study of health-related quality of life in long-term colorectal cancer survivors who answered questions about colostomy irrigation and reported the potential advantages and disadvantages of the procedure. The article also will explore healthcare professionals' role in ensuring patients and family members are educated and well informed about their options regarding temporary or permanent ostomies.

Marcia Grant, RN, DNSc, FAAN, is a professor and director at the City of Hope National Medical Center/Beckman Research Institute in Duarte, CA; Carmit K. McMullen, PhD, is an investigator in the Center for Health Research at Kaiser Permanente Northwest in Portland, OR; Andrea Altschuler, PhD, is a senior consultant at the Kaiser Permanente Medical Care Program in Oakland, CA; Mark C. Hornbrook, PhD, is chief scientist in the Center for Health Research at Kaiser Permanente Northwest; Lisa J. Herrinton, PhD, is a research scientist at the Kaiser Permanente Medical Care Program; Christopher S. Wendel, MS, is a biostatistician at the Southern Arizona Veterans Affairs Health Care System in Tucson; Carol M. Baldwin, PhD, RN, CHTP, AHN-BC, is an associate professor and director in the College of Nursing at Arizona State University in Tempe; and Robert S. Krouse, MD, FACS, is a staff general and oncologic surgeon at the Southern Arizona Veterans Affairs Health Care System and in the College of Medicine at the University of Arizona in Tucson. The authors take full responsibility for the content of the article. This research was funded by a grant from the National Cancer Institute (R01-CA106912). Resources and facilities were provided by Southern Arizona Veterans Affairs Health Care System and the City of Hope Comprehensive Cancer Center. Krouse was a member of the Steering Committee for Malignant Bowel Obstruction trial for Novartis Pharmaceuticals. The content of this article has been reviewed by independent peer reviewers to ensure that it is balanced, objective, and free from commercial bias. No financial relationships relevant to the content of this article have been disclosed by the independent peer reviewers or editorial staff. Grant can be reached at mgrant@coh.org, with copy to editor at CJONEditor@ons.org. (First submission December 2011. Revision submitted February 2012. Accepted for publication March 4, 2012.)

Digital Object Identifier: 10.1188/12.CJON.514-519

About 40,290 patients will be newly diagnosed with rectal cancer in 2012 (American Cancer Society, 2012). Surgery may involve the creation of a temporary or permanent ostomy, and they will join more than 700,000 people in the United States who have an ostomy (United Ostomy Association of America, 2011). A permanent intestinal stoma occurs during surgery for rectal cancer when an anastomosis (reconnection) of the remaining bowel is not an option. Permanent colostomies are most common for low rectal cancers and usually created from the sigmoid or descending colon. The presence of a colostomy has a major impact on patients' health-related quality of life (HRQOL) (Altschuler et al., 2009; Baldwin et al., 2009; Grant et al., 2004; Krouse et al., 2007, 2009; McMullen et al., 2008). A pouch or bag is worn over the colostomy to collect the fecal output. Colostomy care usually involves emptying the pouch daily, multiple times a day, or every other day. The skin surrounding the stoma is cleaned,

and the wafer is typically changed every three to seven days. Specific colostomy concerns include odor or gas, leaking, and skin problems (Grant et al., 2004). Physical challenges involve difficulty sleeping, decreased strength, and fatigue (Krouse et al., 2007). Psychological problems include depression, anxiety, uncertainty, fear of cancer recurrence, appearance changes, and the need for privacy (Krouse et al., 2007). Of special concern are the social challenges that make it difficult for some patients with colostomies to participate in social events such as eating out, traveling, developing new relationships, and participating in intimate activities (Krouse et al., 2009; Mitchell et al., 2007). Spiritual challenges involve changes in the meaning of life and developing and maintaining a sense of inner peace and hopefulness (Baldwin et al., 2008). Some of those concerns may be related to the uncontrolled output of stool from the ostomy.

Because several kinds of pouches and pouching systems are available, patients learn with experience which system works