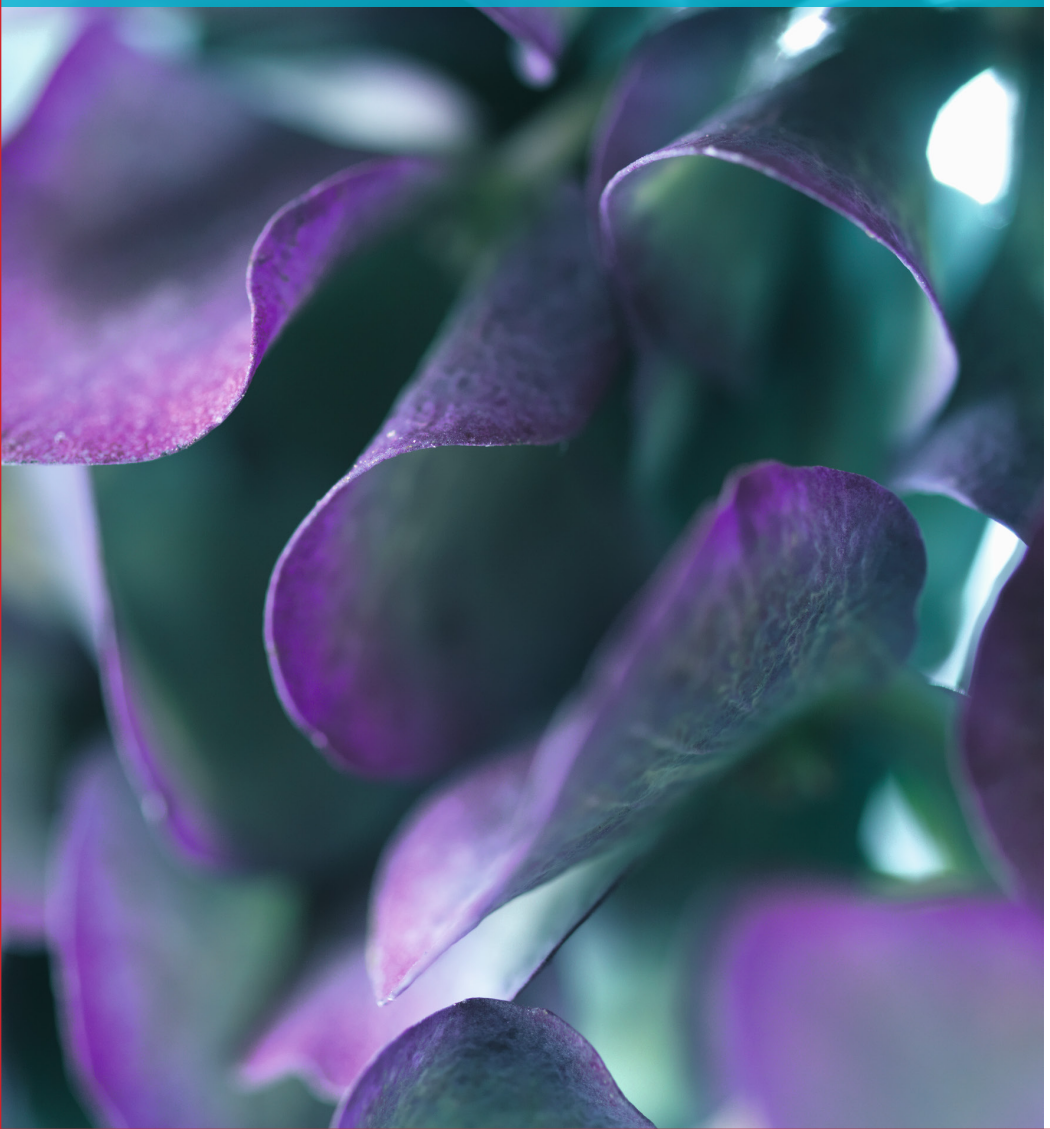
Coloplast

Managing Anterior Resection Toolkit

Guidance for Healthcare Professionals



Foreword

This booklet offers guidance to healthcare professionals whose role involves supporting people who are experiencing (or may be at risk of) Anterior Resection Syndrome (ARS).

The bowel symptoms associated with ARS can be extremely disabling if not treated. This ARS toolkit explains the simple strategies that should be offered. These are encompassed within the following four main steps:

- Education
- Assessment
- Management
- Follow-up Care

The guidance presented here is considered to represent the minimum standard of care which should be offered to all individuals with this syndrome.

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About Anterior Resection Syndrome

Anterior Resection Syndrome is:

- A collection of bowel symptoms commonly experienced after surgery for rectal cancer
- Symptoms include bowel frequency, urgency, incomplete evacuation and loose stools

Anterior Resection Syndrome (ARS) is defined as:

- Disordered bowel function after rectal resection, leading to a detriment in quality of life (Bryant et al, 2012)
- The most useful definition will be the individual's own description of what ARS means to them, since a spectrum of symptoms can be experienced with varying impact upon their day-to-day life

Reasons why Anterior Resection Syndrome might occur:

- Reduced rectal capacity: urge at smaller volumes
- Reduced capacity for water reabsorption
- Alteration in external anal sphincter (EAS) function: particularly after a defunctioning ileostomy
- Poor co-ordination of the muscles used in defecation
- The above effects can result in a loss of perceived control over bowel function and anxiety, which may exacerbate the symptoms experienced

Risk Factors

Low anastomosis

Ileostomy > 12 weeks

Pelvic radiotherapy

Pre-existing bowel dysfunction

Education

Patient education is an essential component of the management of ARS. The following information should be imparted prior to surgery and then ideally reinforced at every opportunity:

- Describe the anatomical changes using visual aids
- Explain the normal defecation process and how an anterior resection can alter this
- Introduce the concept of the '**new normal**' which means they will have to adjust to their bowel function never being as it was prior to surgery (NCSI, 2010)
- Offer reassurance that the great majority of individuals will achieve an acceptable level of bowel function within 12 months
- Highlight that there are many ways in which they can be helped to manage their symptoms thereby minimising disruption to their day-to-day activities and recovery from surgery
- Offer written information (Patient Information Booklet)

> "This information can be delivered over the telephone or in a pre-assessment clinic"

Key messages to make the patient aware of:

- Anterior resection surgery causes a change in the structure and function of the large bowel, this can alter bowel function in the first few months after surgery
- Removal of the rectum, which acts as a storage chamber, causes a loss in rectal capacity
- There can be short-term changes in the motility of the colon and neo-rectum
- Surgery and / or radiotherapy can damage the anal sphincters which are responsible for bowel control

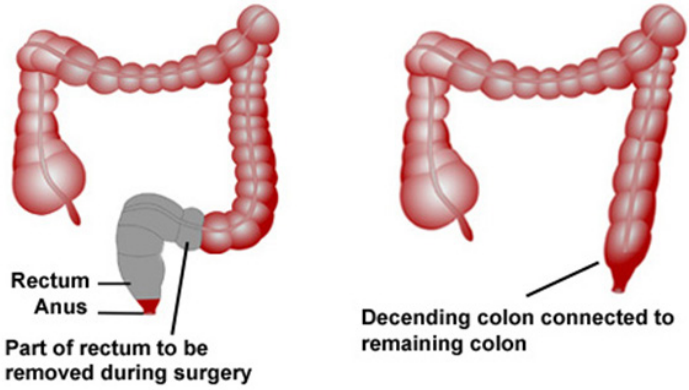

Figure 1: Anatomical changes following anterior resection surgery

Rectal cancers in the proximal (upper two-thirds) of the rectum can be resected and the remaining two ends of the bowel then rejoined, or anastomosed, leaving the anal sphincters intact (as shown in Figure 1).

A low anterior resection will be performed if the cancer is located in the lower third of the rectum, which involves removal of all the rectum and a colo-anal anastomosis. Many surgeons use a defunctioning ileostomy to ameliorate the effects should an anastomotic breakdown occur. The stoma is generally reversed 3-9 months later (Taylor and Varma, 2012).

Assessment

A thorough assessment of each patient's symptoms is key to understanding their experience and is a pre-requisite to effective management.

Assess for ARS within the first 6 weeks of surgery (closure of stoma) and ideally again 2-3 months later.

Include in your assessment:

A determination of stool consistency using the Bristol Stool Chart

1. To assess for faecal frequency ask them:
   "How many times do you go through the day?
   How many times do you go through the night? On average"

2. To assess for faecal urgency ask them:
   "How long can you hold on from feeling the need to open your bowels to actually going?"

   Does stool consistency affect urgency?
   Does the environment they are in make a difference (i.e. if not at home)
   Do they try to resist the urge to defecate?

3. To assess for incomplete evacuation ask them:
   "Do you experience a feeling that you haven't opened your bowels fully after a bowel motion?"

   Do they leave the toilet feeling some motion is still there?
   Do they need to make repeat visits to the toilet to feel empty?
   Remember this may initially be the patient feeling the anastomosis. This usually settles within 12 weeks
   Time of day of evacuations - are patterns emerging?
   Find out what is a good day; a bad day; what is an average day in terms of bowel function

4. To assess for incontinence ask:
   "Do you experience uncontrollable flatus or uncontrollable bowel motion?"

> "Incontinence of **flatus** can be as distressing as incontinence of motion"

- Patients need only experience one episode to cause increased levels of anxiety
- This can lead to severe embarrassment and lifestyle changes
- Enquire about coping strategies i.e. pad use, clothing changes, staying at home
- Urge incontinence (discharge of bowel motion or flatus in spite of active attempts to retain it) should be distinguished from passive incontinence (discharge of bowel motion or flatus without any awareness) (Bliss and Norton, 2010)

5. To gain a complete understanding of current management ask:
   "Tell me what you have tried to manage these symptoms, tell me what has worked and what hasn't"

> "Imodium should be taken **30 minutes** before food"

- Examine their medication including dose, frequency and timing
- Explore foods that trigger bowel symptoms
- Explore toilet behaviour and how this impacts on lifestyle

> "Patients regularly **restrict** food intake as a way to **manage** symptoms"

Anastomotic strictures can occasionally develop after anterior resection surgery (a narrowing in the bowel at the anastomosis). They can cause symptoms which can mimic ARS so this condition should be excluded.

Management

It is important to manage individual expectations from the outset and remind people that their bowel will not return to how it was before surgery. Emphasise that the aim is helping them to achieve an acceptable bowel function and also adjusting to a 'new normal'.

In addition, reassure that control over their bowel function can be regained but that improvements will take several weeks requiring a commitment to both the prescribed therapy and any recommended exercises.

Below are some recommended management strategies. These are for you to utilise and adapt to your individual patient requirements.

Encourage individuals that with appropriate advice and support they will cope with this syndrome.

> "Don't change too much too soon, allow strategies to actually work"

Diet:

- Advise on a low fibre diet, it should be white, refined and low in fibre
- Advise that they can start to slowly increase the amount of fibre once their symptoms are less acute
- Remind them that gut motility medication should be taken 30 minutes before eating
- Advise on a regular diet - skipping meals makes establishing their 'new normal' difficult
    - Offer your patient a low fibre diet leaflet
    - If appropriate, a bowel and / or food diary may identify triggers
    - Patients may have a heightened gastrocolic reflex and may need to void more after meals

Evacuation Technique

- Remind patients to adopt the optimum position for toileting
- Refer to the diagram in their patient booklet and explain if required
- Encourage patients to consciously focus upon relaxing during voiding and avoid excessive straining

    - The optimum position to facilitate complete evacuation of stool is a relaxed squat position; advise that ideally the knees should be higher than the hips, with elbows on knees and straight spine
    - Patients may be aware of the anastomosis for some time, this is normal and will improve in time

Pelvic Floor Regime

> "An anal sphincter exercise regime can be instigated prior to reversal of ileostomy"

- Consider instigation of a pelvic floor exercise regime as early as possible

    - Offer patients access to a pelvic floor exercise leaflet
    - A Pelvic Floor Exercise regime can considerably enhance sphincter function

Pharmacology

- Loperamide (Imodium) is a first line treatment
- Fybogel or Normacol can be trialled to promote more complete evacuation
- Tricyclics can be useful, utilise a multi-disciplinary approach to prescription

    - Patients can be over-sensitive to loperamide, consider using syrup
    - Offer 'How to take loperamide leaflet' (St Mark's website)
    - Empower patients to titrate their medication (with permission)

Follow-up Care

If re-assessment at **12 weeks** demonstrates ongoing symptoms not managed by initial intervention and affecting quality of life, consider the following treatments:

Biofeedback / Specialist Bowel Dysfunction Service

- Anterior resection patients can benefit from a referral to a biofeedback / specialist bowel dysfunction service

Peristeen® Anal Irrigation

- Anterior resection patients can benefit greatly from implementing a plan of rectal irrigation to manage symptoms
- Using irrigation can quickly undo 'severe' symptoms allowing conservative treatment to work more effectively
- Peristeen use may be short or long-term depending upon patient outcomes
    - Not to be initiated before 12 weeks post surgery
    - Gain permission prior to using Peristeen from the patient's Consultant Colorectal Surgeon
    - Anterior resection patients have a smaller capacity; 300ml water volume is a good aim initially
    - Maintain 300ml for at least two weeks and monitor success
    - Anterior resection patients often benefit from two x 300ml irrigations daily to completely eradicate symptoms

Coloplast Care® Bowel Management Programme

- Consider enrolling patients into the Coloplast Care Bowel Management Programme, as part of which they will receive regular telephone support and product guidance
- Utilise the Peristeen Advisory Service for clinical advice and patient training
- Consider registering with a home delivery service, such as Charter Healthcare, to receive future Peristeen supplies

Resources

You may be interested in visiting the following websites for further information and advice regarding bowel symptoms and management:

Bladder & Bowel Foundation
www.bladderandbowelfoundation.org

St Mark's Hospital
www.stmarkshospital.nhs.uk

NICE Guidance for Faecal Incontinence
www.nice.org.uk/CG49

If you would like more information on Peristeen, please visit:
www.peristeen.co.uk

To find out more about the Coloplast Care Bowel Management Programme and the Peristeen Advisory Service, please telephone:
0800 783 1434

For more information about the Charter Healthcare Home Delivery Service, please visit:
www.charter.co.uk

References

- Bliss D Z, Norton C, (2010) Conservative Management of Fecal Incontinence: An evidence-based approach to controlling this life-altering condition. AJN 110(9): 31-37

- Bryant C L, Lunniss P J, Knowles C H, Thaha M A, Chan C L. (2012) Anterior resection syndrome. Lancet Oncol 13(9): e403-e408

- National Cancer Survivorship Initiative (2010) The NCSI.

- Taylor C, Bradshaw E, Walker J, Wood T (2013) Nursing interventions to improve bowel function after rectal cancer surgery. Gastrointestinal Nursing 5(3): 33-38

- Taylor C, Varma S (2012) Factors affecting closure of a temporary stoma. Journal of Wound, Ostomy & Continence Nursing 39(1):51-61

Notes

This toolkit is endorsed by:

Coloplast develops products and services that make life easier for people with very personal and private medical conditions. Working closely with the people who use our products, we create solutions that are sensitive to their individual needs. We call this intimate healthcare.

Our business includes ostomy care, urology and continence care and wound and skin care. We operate globally and employ more than 7000 people.

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