COLORECTAL CANCER is the second largest cause of cancer deaths in the UK (National Institute for Clinical Excellence (NICE) 2004). Many patients with colorectal cancer will undergo bowel resection to remove the tumour. Patients could also require neo-adjuvant or adjuvant therapy in the form of chemotherapy and/or radiotherapy depending on their histology and the location of the cancer (Steele 1999, NICE 2004). At least 40% of patients who undergo colorectal surgery are likely to have a post-operative stoma (Steele 1999, Keating 2004). This might be a temporary measure but could be permanent (Porrett and Daniel 1999).

NICE (2004) reports different rates of stoma formation in England and Wales. Data from the Trent and Wales audits found that 43% of all patients undergoing rectal surgery had formation of a stoma. In Birmingham 50% of patients underwent stoma formation. In contrast some specialist services, such as St Mark’s Hospital in London, reported stoma formation rates to be as low as 10% (NICE 2004). Irrespective of the rate of stoma formation, some patients will experience alterations in body image and sexual function. Quality of life can be reduced and the individual’s ability to cope with activities of daily living such as driving, exercising and sexual activity can be affected (NICE 2004).

White (1998) claimed that 20% of all patients who had stomas would experience psychological symptoms, such as major depressive anxiety and adjustment disorder, as well as sexual difficulties. Virgin-Elliston and Williams (2003) highlighted the fact that such psychological symptoms were still prevalent in this population group.

Many healthcare professionals lack specific knowledge of colorectal cancer and the implications involved in surgical intervention despite caring for patients with the condition (Steele 1999). Patients who require stoma formation experience a number of problems, particularly in relation to body image (Black 2000). Any alteration in the physical appearance of the body can have a profound effect on an individual and it is important that nurses are able to care confidently for patients experiencing changes in body image. Erectile dysfunction and failure to ejaculate are common following anterior resection (the surgical resection of the lower aspect of the descending colon and the rectum) as a result of injury to the hypogastric plexus (Majid and Kingsnorth 2002). The effects of sexual dysfunction, such as retrograde ejaculation, loss of libido and erectile problems, can cause men to avoid intimate situations altogether (Williams 2004).

Women can also experience loss of desire, orgasm and dyspareunia (painful sexual intercourse) as a result of anatomical changes. For example, nerves can be damaged during the surgical removal of low rectal cancers, which can cause vaginal dryness and loss of libido (Majid and Kingsnorth 2002).

Nurses should support patients undergoing colorectal surgery and subsequent stoma formation.
formation to minimise the adverse effects on their quality of life and function.

**Sexual function**

Sexual health has been accepted as a focus for nursing care. However, conservative attitudes, a lack of knowledge about sexuality and sexual dysfunction, and anxiety in relation to discussing these aspects of care are widespread (Webb 1987, Borwell 1997a). Williams (2006) suggests that if nurses discuss sexuality more openly with patients, their patients will be aware that this aspect of their care matters and is important in their care planning.

Sexuality is an integral and complex part of an individual (Black 2000). Sexuality includes sexual behaviour, attitudes and desires, and the psychological and physiological interaction of human sexual response. It has been described as an area that is only discussed occasionally, but is often avoided by nurses (Borwell 1997b).

An important aspect of being a healthy individual is the ability to satisfy the need for love, intimacy and sexual gratification (Maslow 1943). Every person has the right to enjoy a state of sexual health unaffected by illness, age and/or disability (Weston 1993). Despite the sexual activity or orientation of a person it is an important component of the person and cannot be divorced from the individual, even when the person is ill (Van Ooijen and Charnock 1993).

Roper et al (2000) demonstrate this ambivalence towards sexuality in their model of nursing based on activities of daily living. Expressing sexuality is one of the 12 such activities to be assessed. When reading a nurse’s completed assessment of the activities in clinical practice, the information gathered about sexual activity and sexual function is often minimal and refers to how the patient is presented or information about the menstrual cycle. Nurses need to assess the patient’s pre-admission sexual function if they are to identify the degree of post-operative sexual dysfunction.

Despite the promotion of holistic care and the use of nursing models that refer to sexuality as a basic human need, some practitioners lack knowledge and skill in discussing sexual function with patients (Borwell 1997b). Discussions about sexual health should start in the pre-operative phase after agreement between the colorectal nurse specialist and the patient about the management of the individual’s condition. The patient’s usual sexual function needs to be ascertained in the pre-operative phase to make assessment for dysfunction easier post-operatively. Potential problems should also be discussed before discharge and assessed at the first outpatient visit.

Access to services for ward nurses is an important aspect in the management and care of patients following colorectal surgery. Liaison with and referral to specialist surgery is important because they have expert knowledge and skills. For example, patients can be referred to a urology nurse specialist for erectile dysfunction and to a gynaecology nurse specialist for vaginal dryness and/or dyspareunia.

**Literature review**

The literature review began with a search of ProQuest, the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and Ovid. Keywords used in the literature search included sexuality, nurses’ attitudes, colorectal cancer, colorectal surgery, stomas, psychological problems and stomas, and sexual dysfunction. The findings of studies and articles from the nursing literature were examined. No inclusion or exclusion criteria were used as it was felt that any information on colorectal cancer, surgery, functional outcome and nurses’ attitudes was applicable.

**Psychological issues** Empirical studies on the effects of sexual difficulties experienced by those with cancer found that the psychological effects of colorectal surgery and stoma formation were greater than either the physical or pharmacological effects of the condition (Ofman 1995). It is common for a patient to withdraw emotionally, as a coping strategy, after stoma formation. Psychological issues experienced by patients after stoma formation are outlined in Table 1.

Erectile dysfunction can result from surgical intervention or from a fear of rejection and performance anxiety. This, in turn, can lead to tensions in a relationship and withdrawal from intimacy (Borwell 1997a). Many patients find it difficult to discuss sexual feelings, particularly after a change in body image. It is important the nurse is able to help the patient to adapt to alterations in sexual self-concept by exploring the issues with the patient (Salter 1997).

Conversations with patients about sexual matters can be challenging due to the content of discussion and the environment where it is being discussed, such as a hospital bedside or clinic. It could be challenging because the nurse or patient is embarrassed. Such discussions may become less challenging if we are open to talking about the issues (Bor and Watts 1993). Patients do not often disclose psychological factors about adjustment to stoma surgery, unless specifically asked or a routine enquiry is made by the nurse (White 1998). Nurses require sufficient time and training to enable them to elicit this information and to deal with situations relating to a patient’s sexual health (Gregory 2000). According to Joels (1989), sexuality and the effect of colorectal surgery on sexual function is often avoided by nurses (Borwell 1997b).
A literature review of functional outcomes following rectal excision was carried out by Keating (2004). The review concluded that the effect of rectal excision on sexual function in women did not get as much attention as in men. Keating (2004) demonstrated that an excision of the rectum with total mesorectal excision carried a 40% risk of erectile dysfunction, and that anterior resection carried a 20% risk of erectile dysfunction. Clarke et al (2004) examined functional outcomes following colorectal surgery, focusing on sexual, urinary and bowel problems. The quantitative study of 110 men and women who had undergone colorectal surgery was carried out between 1989 and 2002. It demonstrated that there was no profound effect on sexual function following an anterior resection; the reported incidence of dysfunction was 4-5%. Time since surgery varied from two to 15 years, helping to demonstrate the associated short and long-term functional outcomes of colorectal surgery (Clarke et al 2004).

Other factors that can contribute to sexual problems in women include parasympathetic denervation — damage to the parasympathetic nerves — which can cause reduced vaginal secretion and vaginal dryness. Changes in the pelvic anatomy can be caused by low rectal surgery and removal of pelvic organs. Radiation damage from radiotherapy to the pelvic area can also lead to such problems. Following colorectal surgery, women are more likely to experience damage to the vagina, reduced vaginal secretion and loss of libido (Ofman 1995).

Bambrick et al (1996) investigated the effects of colorectal surgery on female sexual function. The retrospective qualitative study focused on women and their experience of changes in sexual function in the post-operative period. The aim of the study was to identify the incidence and type of problems experienced by women after undergoing restorative proctocolectomy — also known as internal pouch formation, where the colon is removed and an ileo-anal or ileo-rectal pouch is formed. A questionnaire was sent to 262 females who underwent restorative proctocolectomy between 1984 and 1993. Ninety-two women responded giving a response rate of 35%. The mean follow-up time for these patients was 43 months (from six to 130 months). The results of this study demonstrated that, following surgery, there was a significant increase in vaginal dryness, dyspareunia and limiting of sexual activity because of concerns of stool leakage. However, there was no significant change reported in sexual desire, arousal, sensitivity, frequency of intercourse or satisfaction with sexual relationships (Bambrick et al 1996).

The study showed the incidence of women experiencing dyspareunia was 24% (22/92), after...
restorative proctocolectomy (Bambrick et al 1996). There was a poor response to this questionnaire and it could be argued that the findings might not be significant because of this. The remaining 170 patients might not have wanted to disclose personal information.

A recommendation made by Bambrick et al (1996) was that potential problems – such as erectile dysfunction and dyspareunia – should be discussed by the surgeon pre-operatively. Borwell (1997a) identified that nurses discuss issues of sexuality and sexual dysfunction with patients, however this was with male patients only (Borwell 1997a). The occurrence of dyspareunia appears higher in more recent studies (Keating 2004), but this could be the result of an increase in acknowledgement, awareness and reporting of the condition.

Although the extent of functional problems can only be determined post-operatively, it is still important to make the patient aware of potential problems during the pre-operative phase.

Porrett and Daniel (1999) state that the possibility of nerve damage that causes dysfunction following rectal excision should be discussed with the patient before surgery. As part of obtaining informed consent from the patient, information provided should include the risks, inconvenience and discomfort related to the procedure (Jameton 1984).

Relationship issues Persson et al (2004) conducted a qualitative study using focus group interviews as a method of data collection. The study examined spouses’ perceptions and reactions to living with a partner who underwent surgery for rectal cancer which resulted in a stoma. Altered body image was one of the central themes of this study, but sexuality and sexual relations with spouses are also explored. Some women thought that stoma formation had affected their husband’s personality and self-esteem. In some cases it was reported that men did not feel masculine post-surgery.

Spouses also described great changes in their relationships, claiming that their partners had become more reserved and refrained from intimate contact. It was found that nurses did not provide any information about erectile dysfunction, or the psychological implications of stoma formation, to either the patient or carers. This might have been because of the taboo nature of sexuality as well as a lack of knowledge on the nurse’s part. It is also possible that the spouses did not recall being given this information (Persson et al 2004).

Nurses’ attitudes An important part of the nurse’s role is the ability to convey information to support patients in their treatment choices and to obtain informed consent. Discussions about the patient’s sexual health can be challenging for nurses who might choose not to initiate such conversations because they feel embarrassed (Waterhouse 1996, Borwell 1997a, Cort 1998, Palmer 1998, Williams 2004).

Webb (1987) carried out research on nurses’ attitudes to patients’ sexuality. The findings illustrated that nursing staff demonstrated a tendency to consider patients’ sexual problems as an inappropriate area of nursing care. The rationale for this included: sexual issues being perceived as unimportant compared with the struggle to overcome disease and cope with treatment; embarrassment on the part of the nurse; and the nurse’s lack of knowledge about sexual problems.

Discussing sex and relationship issues requires sensitive communication. Nursing staff need to gain confidence in addressing issues of sexual health to offer patients appropriate and holistic care. It is helpful when precise clinical guidelines are available that provide a team approach to managing sexual problems (Gregory 2000). Most NHS providers have specialist nurses trained to deal with problems relating to patients’ sexual health who can offer help through nurse-led clinics. Alternatively, a referral protocol should be in place. If in doubt nurses should contact the local colorectal or urology nurse specialist who can offer assistance and advice.

Cort (1998) presented the findings of a qualitative survey on nurses’ attitudes to sexuality in caring for cancer patients. One of the central themes was that nurses might be aware of the issues that relate to sexuality and palliative care, but this aspect of nursing cannot be routinely or formally addressed with confidence (Cort 1998). A questionnaire was sent to 50 nurses working in a London hospice. The questionnaire used a Likert scale to elicit attitudes towards the sexuality of patients with cancer. The response rate was 66% (n=33). Ten nurses volunteered for interview post-questionnaire, and five were randomly selected. All nurses had significant experience working in oncology.

The research confirmed that nurses held broadly liberal views and, although some uncertainty was noted in relation to particular issues, anxiety was not apparent. The study did establish that nurses appeared less confident when dealing with issues specifically related to sexual functions (Cort 1998). Although it appears that nurses are becoming increasingly aware of the significance of sexuality and sexual health in patient care, perhaps more attention needs to be focused on this aspect of nursing in clinical practice (Palmer 1998).

A study by Borwell (1997b) explored the psychosexual needs of the patient. This was carried out using a multimethod approach to gain further understanding of the nursing practice and
role preparation of stoma care nurses in the UK in relation to sexuality. Using a quantitative approach, a 36-item self-report questionnaire was used to predict and understand the behaviour of stoma care nurses in relation to their role. The questionnaire included sequential, filter and contingency rating scales as well as open and closed questions (Borwell 1997b). The results were as follows (n=292):

- About 90% of stoma care nurses had a positive attitude to sexuality, stating that they would incorporate sexuality into discussion with patients in practice.
- Almost 50% felt uncomfortable discussing some aspects of sexuality with patients.
- A further 25% of stoma care nurses displayed a negative attitude to discussing some sexual practices.
- Only 11% routinely incorporated a sexual history in the care of patients.
- About 84% of stoma care nurses had not received any formal training on how to complete an assessment, including taking a sexual history and a general sexual assessment.

- About 72% of nurses highlighted the need for further education.

Borwell (1997b) concluded that reluctance to discuss sexual or psychosexual issues suggests that the topic of sexuality is not raised with two thirds of patients. Although some nurses discuss sexuality with patients, it appears that conversations are formed on a superficial basis and that not all areas of sexuality are discussed. Palmer (1998) highlighted two broad issues affecting sexuality in nursing practice. First, nurses should appreciate that sexuality and sexual health can be affected by treatment and illness. Second, nurses can have negative attitudes to patients’ sexuality.

Conclusion

The evidence suggests that sexual dysfunction, whether it is vaginal dryness or dyspareunia, arousal disorder or erectile dysfunction, is a problem for some patients following colorectal surgery. The literature demonstrates that this area of nursing care is not addressed comprehensively. Nurses have a duty to provide holistic care for all patients. Nurses should be educated in the various aspects of sexuality, sexual dysfunction, body image and altered body image, and provided with information and strategies on how to address and approach these issues with patients in a sensitive manner.

References


