The role of the Colorectal Nurse Practitioner

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Aims of presentation

- Provide understanding of the role
- Give an insight into CCFU clinics and the patients pathway
- Explain the role of the NP in the 2ww service
CCFU Clinics
If detected early, recurrent disease may be amenable to surgical resection. This provides the rationale for a follow up strategy in patients with resected colorectal cancer.

Despite trials reviewing different strategies, still no consensus as to the appropriateness of FU in CRC.

Historically

- Wide variation in F U care received
- Often seen by junior Doctors
- No timely ordering of investigations
- Who followed these up and acted on any abnormal results?
- No relationships or continuity of care
Benefits of Nurse Led FU

- Management of functional problems – bowel, sexual, urinary
- Provide continuity of care
- Promote survivorship
- Support patients and families
- Give specialist knowledge and advice
CNS ROLE IN CCFU

- Over 600 patients in Nurse led FU
- Majority of CRC patients referred into service
- Work to protocols
- Historically 5 year FU changed 09/11
- Transfer of care to primary care at 2 or 3 years
Why change how we deliver FU?

- Few recurrences are picked up at clinic visits
- Research shows that most recurrences occur within the first 2 years post-op
- Intensive FU in first 2 years
- Signs and symptoms of recurrence discussed
- Promoting survivorship
Colorectal Cancer Follow up protocol 2011

Refer Nurse led fu

- Protocol applies to all ‘curative’ patients
- All patients to be referred to nurse led follow up for Holistic Needs Assessment (can also remain on Consultant follow up if complex case).
- Please ensure conformity to this protocol unless deemed inappropriate.

Contact details: Nurse Led CRC FU Ext 14809
**F U protocol**

- First visit 3 months after post-op appt with consultant
- HNA pre first and last appointment
- Clinic appts at 3, 9, 15, 24 months
- 3 monthly CEA
- CT chest, abdomen and pelvis at 9 and 24 months
- Colonoscopy at 6/12 months post-op
- Transfer of care to GP at 2 or 3 years
Holistic Needs Assessment

- SPARC tool used in Sheffield (Sheffield Profile for Assessment and Referral to care)
  - Sent to patients to complete before first and last appointment
  - CNS reviews and formulates an action plan
  - Any patient with serious concerns can be identified and contacted early
  - Issues addressed before transfer of care back to GP
Carcinoembryonic antigen
- Usually present at low levels in healthy adults
- Can be a useful ‘tool’ to detect recurrence
- Some people are ‘non-secretors’
- Smokers often have high levels
- Protocol – 3 consecutive rises in CEA – CT scan
What do we want to know?

- Bowel function
- CIBH
- Blood in stools
- Abdo pain
- Loss of appetite
- Weight loss
- Abdominal mass
Who stays with us?

- Rectal cancers (3 years)
- Recurrent disease
- Functional bowel difficulties
- Psychological problems
Who can help?

- Urological services
- GI physiology
- Psychological services
- Cancer Support Centre
- Cavendish Centre
- Stoma care team
What else do we do?

- Attend the Sheffield Bowel Cancer Support group meetings
- Core member of ABC group
- Offer help with the CALM course run by CSC
- Participate in research studies
2 Week wait clinic
Nurse led clinics

- Decision to refer from GP on 2WW suspicion of cancer pathway
- Nurse led see approx 24 pts/week
- Work to strict protocols
- All patients are under consultant care
Benefits for patients?

- Appropriate skills at appropriate time
- 30 min clinic slots/10 mins for Doctor
- More time to spend with the patient
- Investigations followed up and acted on quickly
- Patients know who to contact with any problems or questions
Presenting symptoms

- Rectal bleeding
- CIBH
- IDA
- Weight loss
- Abdominal/rectal mass
At first appointment

- Explain purpose of service
- History taking
- Physical examination
- Discuss with medical staff if necessary
- Agree plan of investigation
- Give contact details
History taking

- Colorectal symptoms
- Change from their norm
- Duration
- Severity
- Impact on quality of life
History taking 2

- Blood in stools
- Abdominal pain
- Anaemia
- Abdominal mass
- Weight loss
- Tenesmus
History taking 3

- Past medical history
- Family history
- Drugs / allergies
- Smoking / alcohol
Physical examination

- Abdomen
- Rigid Sigmoidoscopy
- Proctoscopy?
Investigations

- Any
- Flexible sigmoidoscopy
- Colonoscopy
- CT pneumocolon/scan
- MRI
- USS
- Bloods
- 31/62 stamp
Behind the scenes

- Collating & acting on findings
- Interpreting results
- Pathway co-ordinator
- Contact point for support ‘Key-Worker’
What do we find?

- Nothing to explain symptoms
- Haemorrhoids
- Diverticular disease
- Microscopic colitis
- IBD
- Cancer
- Other pathologies (not CRC)
Results – Benign

- Remove suspicion of cancer
- Remove from 2WW pathway
- Discharge back to GP
- Letter to patient with results of investigations
- Information leaflets
- Refer on if necessary
- Health promotion
Results – Cancer

- Support patient with their diagnosis
- Complete staging investigations
- Presentation of patient at MDT
- Team plans choice of treatment
- Keyworker role – see patient in clinic with consultant – ongoing support
Treatment plan

- Pre-op chemo/rdx
- Surgery Lap/open
- Colonic Stent
- Endoscopic resection
- Palliative chemotherapy
- Best supportive care
Case study 1

- 80 year old male
- 6 week history CIBH
- Centralised abdo pain
- Bloating
- Tenesmus
- Weight loss 1 stone in 1 month
- Recently attended A/E with abdo pain
  no investigations performed
PMH

- CABG 1998
- Cholecystectomy 2005
- Non-Hodgkins lymphoma
- Diabetes Type 2
- Hypothroidism
On examination

- Looks unwell
- DRE normal
- D/W colorectal consultant
- For CT scan in first instance
Outcome

- CT shows progression of Non-Hodgkin lymphoma
- Referred back to Haematology
- Patient died 1 month later
Case study 2

- 21 year old male
- 1 year history of CIBH
- Increasingly worse in last month
- Bowels opened 10x day
- Nocturnal defeacation
- Tenesmus
- Weight loss 1 ½ stone in 6 weeks
- IDA  Hb 9.5
On examination

- Pale
- Looks unwell
- Anxious
- Abdomen NAD
Outcome

- Bi directional endoscopy
- Colonoscopy shows polyposis
- Gastroscopy – polyps
- CT – Large mass in rectum
- Liver and lung METS
- Referred to teenage cancer unit at WPH
Case study 3

- 80 year old female
- 3 month history of CIBH
- Abdominal discomfort
- Weight loss 1 stone in 3 months
- Recent gastroscopy for weight loss – NAD
PMH

- Bilateral inguinal hernia repairs
- Varicose vein surgery
- Still working as a teacher
- About to move house
On examination

- Looks pale
- Abdomen distended
- Multiple small nodules felt on abdominal examination? Lipomas? Peritoneal METS
- DRE normal
Outcome

- CT scan shows advanced intra abdominal malignancy
- Ascites peritoneal deposits
- Omental deposits
- ? Primary site
- CA125 720*
- Omental biopsy ? Metastatic cholangiocarcinoma
- Patient died 5 weeks later
Future development of the service
Expanding the team

- **Staff Nurse – Colorectal/Stoma x 2**
- **Location:** Colorectal – Surgical Care Group
- **AFC Band:** 5
- **Hours Per Week:** 34hrs x 1 post and 15hours x 1 post – permanent contract.
What about me?
Thanks

Any questions?