Treatment trajectories of individuals diagnosed with rectal cancer: an interpretative phenomenological study

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ABSTRACT

Rectal cancer affects almost every aspect of an individual's daily life. However, there are gaps in understanding the complete spectrum of experiences spanning from diagnosis to recovery. Therefore, the aim of this study was to explore the treatment trajectories of individuals diagnosed with rectal cancer. Adopting an interpretative phenomenological approach, seven participants were recruited using purposive sampling. Data were collected using semi-structured, in-depth interviews that were digitally recorded, transcribed and analysed using thematic analysis. Study rigour was established following the four-dimension criteria of credibility, dependability, transferability and confirmability. Four prominent themes emerged from the participants' experiences of undergoing rectal cancer treatment: uncovering the inner battles; navigating the physical challenges; anchors of support and conquering the summit. These findings contribute to knowledge and practice by highlighting the importance of providing a comprehensive and individualised treatment plan for individuals that takes account of the physical and psycho-emotional implications of rectal cancer treatment.

Key words: Rectal cancer ■ Cancer treatment ■ Stoma ■ Lived experience ■ Interpretative phenomenology ■ Thematic analysis

Colorectal cancer (CRC), commonly referred to as colon, rectal or bowel cancer, is the third most common cancer diagnosed worldwide, with more than 1.9 million new cases reported during 2020 (World Cancer Research Fund, 2023). In the UK, CRC is the fourth most common cancer, with an estimated 42 886 people diagnosed each year and approximately 16 800 recorded deaths per annum (Cancer Research UK, 2023a). According to Bowel Cancer UK (2024), more than nine out of every 10 new cases of CRC are diagnosed in adults aged over 50, whereas approximately 2600 new cases are among those aged under 50 each year.

Although the incidence of CRC has risen, survival rates have doubled during the past four decades. According to Bowel Cancer UK (2024) around 268 000 people living in the UK today have been diagnosed with bowel cancer. Recent figures report that three in every four individuals survive their cancer in the first year after diagnosis (NHS Digital, 2023).

Improved survival rates have been linked to a number of advancements, including early detection, diagnostic procedures, treatment strategies and post-treatment monitoring. For rectal cancer, laparoscopic and robotic surgery (Lirici and Hüscher, 2016) in combination with enhanced surgical skills and expertise has made sphincter-saving surgery possible and, in some cases, eliminated the need for a permanent stoma.

The treatment trajectories for rectal cancer hinge on a number of factors such as the cancer site and radiological staging outcomes. Employing both computerised tomography (CT) and magnetic resonance imaging (MRI), clinicians endeavour to offer a prognostic assessment for each patient (Benson et al, 2022). A CT scan examines the chest, abdomen and pelvis to detect the primary cancer, metastatic disease and to gauge the stage of the cancer (National Institute for Health and Care Excellence (NICE), 2021). On the other hand, an MRI scan provides intricate images of the rectum, revealing whether the cancer has breached the layers of the bowel wall and invaded the nearby lymph nodes. The information gleaned from each of these scans enables clinicians to determine an optimal management plan for their rectal cancer patient (Moran et al, 2017). In instances where rectal cancer is sizeable, poses a threat, breaches resection margins, encroaches onto the inter-sphincteric plane, or involves the levator, consideration is given to downstaging treatment (NICE, 2021). Treatment options may encompass downstaging chemotherapy, followed by chemoradiation (either a short course of 5 days or a long course spanning 5 weeks), succeeded by a waiting period (8 to 12 weeks) preceding surgery (Moran et al, 2017; NICE, 2021).

The objectives of rectal cancer surgery encompass four key elements: the resection of the primary cancer, prevention of local recurrence, preservation of the autonomic nervous system, and safeguarding of the anal sphincter (Grazzini et al 2023). Recognised as the optimal approach, total mesorectal excision (TME) is the gold standard for rectal cancer surgery,

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demonstrating a notable reduction in local recurrence rates. According to Heald and Moran (2021) the principles of TME are integral to surgical techniques, be they laparoscopic or open procedures.

Despite advancements in treatment, the management of rectal cancer can adversely affect the lives of patients. Quality-of-life outcome measures have revealed difficulties with daily functioning, including physical activity (Hubbard et al, 2020), appetite loss and dietary adjustments aimed at managing bowel functions (Appleton et al, 2013). Saunders and Brunet (2019) found that treatment-related barriers such as fatigue, nausea and neuropathy reduced engagement in health-promoting activities. Moreover, other outcomes associated with rectal cancer treatment include stoma leakage, clothing discomfort (Neuman et al, 2011), body image issues (Song et al, 2020) and sexual dysfunction (Chan et al, 2023). Han et al (2020) highlighted that, with increased CRC survival rates, overcoming fears of recurrence and adjusting to a new normal are among the long-term problems linked with the post-treatment period. For some individuals, these adjustments can be achieved within months, while for others, it can result in long-term physical, psychological and social challenges.

In their meta-analytical review of 15 peer-reviewed qualitative and mixed-method studies spanning up to 2019, Rutherford et al (2020) observed that individuals frequently grapple with persistent and unpredictable gastrointestinal symptoms as well as functional impairment extending beyond 1 year following the completion of CRC treatment. These individuals often opt to self-manage unpredictable symptoms such as issues related to bowel and sexual function, instead of seeking professional assistance. However, treating these symptoms with self-care may inadvertently exacerbate rather than alleviate them, potentially leading to the development of chronic issues.

Recent studies have also focused on heterogenous treatment approaches such as the impact of altered bowel function after sphincter-saving surgery and stoma reversal, commonly known as low anterior resection syndrome (LARS) (Pieniowski et al, 2020; Burch et al, 2021; Li et al, 2023). Heightened frequency, urgency, difficulties with evacuation, flatus and/or stool incontinence that culminate in toilet reliance, preoccupation and dissatisfaction with bowel movements, have all been identified as consequences of sphincter-saving surgery and stoma reversal (Lu et al, 2017; Reinwalds et al, 2018). A systematic review of post-reversal symptoms found that patients experienced embarrassment and stigma (Pape et al, 2021). Individuals emphasised the significance of personal and healthcare support, stressing a need for greater provision to help navigate the aftermath challenges of stoma reversal.

Box 1. Examples of semi-structured interview questions

- Can you tell me when you were first diagnosed?
- Can you tell me about your treatment journey?
- Can you tell me about the symptoms you experienced during treatment?
- Can you tell me about having a stoma?
- Can you tell me about the support you received?

Although recent studies have provided valuable insights, there is scope for a deeper understanding of the experiences of individuals diagnosed with rectal cancer, encompassing the period from diagnosis to recovery. Several qualitative studies have explored patient-reported outcomes, specific treatment points, and the consequences of altered bowel function, such as LARS. These studies, however, often combine data from individuals diagnosed with both colon and rectal cancer without presenting distinct findings for each. Due to the variations in treatment approaches for colon and rectal tumours, the amalgamation of data can impede a nuanced understanding of outcomes and experiences unique to rectal cancer survivors. Furthermore, although research has identified the adverse effects and challenges faced by individuals undergoing rectal cancer treatment, the psychological and social dimensions of their experiences warrant further exploration. Given the critical nature of these observations, an examination of the rectal cancer treatment trajectory could contribute to a more comprehensive understanding of its overall impact on the lives of individuals.

Aim

The aim of this study was to explore and understand the treatment trajectories of individuals diagnosed with rectal cancer spanning diagnosis to recovery.

Method

Design

The qualitative study adopted an interpretive phenomenological approach informed by the philosophical thinking of Heidegger: 'being in the world' (Clark, 2011).

Study setting and recruitment

Participants were recruited from a local healthcare colorectal cancer database using purposive sampling. Those who had undergone rectal cancer surgery in the past 10 years, who had formation of a temporary or permanent stoma, were aged over 18 years old, literate in English and able to provide consent to participate in the study, were eligible. Time from completing rectal cancer treatment was more than 1 year. The first author identified and initially approached potential participants by telephone; this action was followed up with the provision of more detailed study information.

Data collection

Data were gathered using a semi-structured interview approach. Questions were constructed to promote freedom of expression among participants and to enable the researcher to probe, as required. *Box 1* presents question examples. A single pilot interview prior to data collection was undertaken to check for clarity, style and timing (O'Leary, 2017). Interviews (n=7) were conducted in person by the first author, lasted approximately 1 hour and were conducted in a location of each participant's choice.

Interview data were digitally recorded, transcribed and anonymised. Field notes were also documented after each interview to capture relevant contextual information (Phillippi

and Lauderdale, 2018). Due to the potential emotional impact that an interview can have, participants were contacted 1 week after the data were collected, to gauge their wellbeing.

Data analysis

Aligned with the study's interpretative phenomenological design, thematic analysis was undertaken guided by Braun and Clarke's (2006) framework. Data were analysed by the first author through the process of familiarisation, the generation of codes and themes and by reviewing, defining and labelling the final four themes. The use of visual mapping during the coding process enabled meaningful interaction and freedom to integrate, classify and connect with the data. Data analysis commenced once the first interview was completed.

Ethical considerations

The Faculty of Health and Social Care Research Ethics Committee, at the University of Chester (ID RESC0418-918), approved this study. Additionally, ethical permission to access participants was gained from the local health organisation's Research Ethics Committee. Ethical considerations including informed consent, a right to withdraw, confidentiality, adherence to data protection and dissemination of study findings, were observed.

Rigour and reflexivity

Rigour was ensured by adhering to Lincoln and Guba's (2013) guidance for trustworthiness. The four criteria of credibility, transferability, dependability and confirmability were met using strategies that included peer-debriefing, member checking and maintaining field records. Robust methodological information was provided to support transferability and confirmability was ensured by using direct participant quotes to demonstrate how interpretations were rationally and cogently created. Reflexive journalling was used to maintain a record of all research-related decisions (Johnson et al, 2020).

Results

Participant characteristics

Four women and three men aged between 44 and 71 years took part in the study (*Table 1*). Six participants were married and one was single. All participants had been radiologically and histologically diagnosed with stage 3 rectal cancer.

Five participants had a temporary ileostomy, one had a temporary colostomy, and another had a permanent colostomy. Treatment timescales from stoma formation to completion of treatment ranged between 2 and 15 months (*Table 1*). Stoma reversals were delayed due to the participants undergoing adjuvant chemotherapy. Among the participants only one reported a physical comorbidity while none cited any mental health comorbidities. One participant had passed 1 year since completing treatment, five participants had reached the 3-year mark post-treatment and one participant had concluded their treatment 8 years previously.

Participants received various combinations of cancer treatment, the most common being anterior resection, stoma and adjuvant chemotherapy (*Table 2*).

Table 1. Participants' demographic characteristics and number of months with a temporary or permanent stoma

Personal identifier number	Male/female	Age	Marital status	Number of months with a temporary stoma
1	Male	52	Married	6
2	Female	44	Single	12
3	Female	59	Married	9
4	Male	55	Married	2
5	Female	71	Married	15
6	Female	44	Married	9
7	Male	60	Married	Permanent colostomy from surgery

Table 2. Types of treatment received

Treatment types	Number of participants
Downstaging chemotherapy, chemotherapy/radiotherapy (long course), anterior resection and ileostomy	1
Downstaging chemotherapy, chemotherapy/radiotherapy (long course), Papillon therapy, abdominal-perineal excision of rectum	1
Downstaging chemotherapy, short course radiotherapy, anterior resection and ileostomy	1
Anterior resection, ileostomy and adjuvant chemotherapy	3
Hartmann's and adjuvant chemotherapy	1

Themes

The findings of the thematic analysis are presented below in the context of an interpretative phenomenological study that explored participant treatment. The results are organised around the four main themes and are presented in *Figure 1*:

- Uncovering the inner battles
- Navigating the physical challenges
- Anchors of support
- Conquering the summit.

Theme 1. Uncovering the inner battles

This theme reflected the psychological and emotional effects of a rectal cancer diagnosis, treatment and recovery on individuals.

Fear

Two participants spoke about the initial emotional effect on receiving their rectal cancer diagnosis. The mere mention of the word 'cancer' was enough to evoke fear even before any specific details were discussed:

> **'As soon as you mention the word cancer, it scares you … I was scared.'**
>
> *Participant 4*

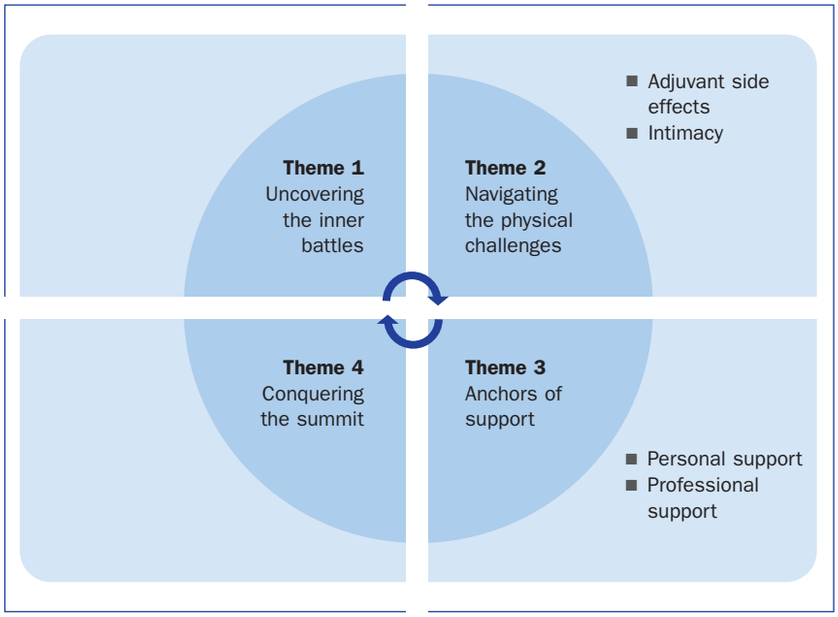

Figure 1. Study themes and subthemes of lived experiences of rectal cancer treatment

Participant 7 pondered on how his diagnosis triggered a significant and instant shift in his life, introducing a sense of uncertainty and necessitating adaptations to address the challenges associated with cancer:

> **'It was a shock … I couldn't believe it at first. As soon as you are diagnosed that's it, your normal life is taken away from you.'**
>
> *Participant 7*

For others, however, their fear materialised through a deep-rooted apprehension about living with their stomas, driven by their unpredictable nature. One participant described the constant worry of odour and social perception:

> **'I constantly thought I smelt. I was living on my nerves … I would not go very far from home.'**
>
> *Participant 2*

Experiences of stoma leakage intensified their fears:

> **'Having a bag of [faeces] running down your leg, and just always leaking …'**
>
> *Participant 4*

For some, their fear of judgement led to social isolation and reclusiveness:

> **'I had visions that everybody was looking at me … I didn't want to go out anywhere or do anything.'**
>
> *Participant 3*

Other participants worried about infection and the practicalities of managing their stoma when at work:

> **'I didn't want to go to work because I didn't want to catch any germs … nor did I want to deal with my bag whilst I was at work … it completely controls your life.'**
>
> *Participant 6*

Suicidal ideation

The challenges of rectal cancer treatment proved overwhelming for three of the participants. They candidly shared the impact of treatment on their mental health as they managed the consequences of surgery with the formation of a stoma and adjuvant chemotherapy. Participant 2 described how her experiences of dealing with the unpredictability of the stoma output and leakage coupled with the side effects of chemotherapy had taken her to her lowest psychological point:

> **'It got to the stage that I didn't really care, I couldn't go on … I was suicidal … remember thinking, I can't do this anymore … that's when you know you are at rock bottom because you are at the lowest level of life that you will ever be … I just wanted to go to sleep.'**
>
> *Participant 2*

The harsh realities of experiencing constant leakage from their stoma appliances and a need to depend on family for assistance had induced feelings of depression. Participant 4 reluctantly admitted how these experiences had driven him to consider the act of ending his life:

> **'You wouldn't want to know what I thought … I had got so low … wanted to commit suicide when I had that [stoma] … I could have quite easily switched off, if there were a switch, without a doubt.'**
>
> *Participant 4*

However, all three participants who had emphasised feelings of low mood and suicidal ideation reported how the interventions provided by health professionals had helped steer them through some of their darkest periods:

> **'… without people like you [the clinical nurse specialist] where would we be, we wouldn't be here, we would be dead or committed suicide.'**
>
> *Participant 5*

Feelings of antipathy

The unsightliness and constant activity of stomas evoked feelings of shock, disbelief and distress. One participant compared her ileostomy to living with an alien. Feelings of being repulsed and disgusted were amplified when her bowel became active and produced unpleasant odours:

> **'It's like a live piece of your bowel that's on your stomach, it felt [like an] alien … when it was active, it was smelly.'**
>
> *Participant 6*

For some, the presence of an ileostomy was more emotionally traumatic than the initial cancer diagnosis:

> **'The cancer didn't come into it … I thought this is my life over … I wouldn't be able to do anything ever again [with] having the bag.'**
>
> *Participant 2*

Another participant echoed this sentiment:

'I know cancer should be your biggest fear but having a stoma bag was such a traumatic thing … one of the hardest things to deal with.'

Participant 5

Theme 2. Navigating the physical challenges

This theme highlights the physical challenges experienced by the participants, related to the side effects of chemotherapy, radiotherapy and intimacy.

Adjuvant side effects

Chemotherapy induced various side effects, including sensitivity, severe coughing, breathlessness, nausea, indigestion, low mood, poor appetite, weight loss and residual peripheral neuropathy:

'I had no energy, was feeling nauseous, it made me very depressed. I couldn't eat. I couldn't even smile.'

Participant 2

'It was scary … you couldn't breathe and that really frightened me.'

Participant 3

One participant noted that the method of chemotherapy administration affected the severity of side effects:

'… the second lot, because it was through the PICC line, I didn't find the side effects as severe.'

Participant 1

For some, the treatment journey resembled a roller coaster characterised by cycles of highs and lows, featuring periods of lethargy and elation:

'For the first week you are completely zapped of your normal energy, and you feel quite tired, low in mood … then you start to bounce back up.'

Participant 6

Another participant recounted the arduous effects of Papillon therapy, comparing it to feeling violated:

'For a week later I was shaking my head because I felt I had been raped … it was the most traumatic thing I've ever had.'

Participant 7

These feelings were exacerbated when their treatment resulted in an abdominal perineal excision of the rectum:

'My bottom being taken away was the most traumatic thing I had [experienced] through the whole treatment.'

Participant 7

Intimacy

Participants described the physical challenges that can emerge within relationships when one partner faces health issues such as rectal cancer. They candidly shared their experiences regarding the delicate boundaries of intimacy:

'No we never did [have sex]. Cuddles, but nothing more.'

Participant 5

Several recounted the hurdles they faced in maintaining their sexual wellbeing during treatment, including a diminished interest in sex, fatigue during intimate moments and issues such as penile lymphoedema. Consequently, sexual intimacy was notably absent for a number of participants:

'… tiredness, lack of libido, swelling of the penis and the skin around the penis was quite tight … my sex life doesn't exist.'

Participant 7

The impact of rectal cancer on intimacy led Participant 2, who was single and living with a stoma, to rule out the possibility of a future sexual relationship:

'Oh my goodness never in a million years, no chance … I physically would never ever put myself in that situation.'

Participant 2

However, differing perspectives existed within relationships. One participant contrasted her experience to her husband's, explaining how her stoma made physical intimacy challenging for her; in contrast, it was not an issue for her husband:

'I did find having any kind of intimacy with my husband difficult. He didn't find it difficult.'

Participant 6

Theme 3. Anchors of support

Support played a crucial role in individuals' treatment trajectories, falling into two categories: personal and professional support.

Personal support

Support came in different forms, primarily from family members including their spouses, children, parents and siblings. They played distinct roles in helping with the challenges of their condition:

'My husband came to all the appointments with me whilst my daughter came to all the chemotherapy with me.'

Participant 3

These forms of support encompassed practical, emotional and social aspects:

'Everybody gave me support in different ways … my husband was the emotional support, and my mum was the practical support. The kids would tend to ask every now and then "how are you Mum?" …'

Participant 6

Many participants recalled how family had helped them cope with the initial shock of their cancer diagnosis and how they had enabled them to view the situation optimistically:

'We put a good positive spin on it in that bowel cancer is one of the most successful cancers to treat.'

Participant 5

Some participants initially hid or downplayed their diagnosis to protect loved ones. These intentions, however, could sometimes cause distress:

> **'The one thing I did really wrong is that I wasn't open and up front with my daughter … I was protecting her and it's only now I realise it, coz anytime I mention a hospital, she panics …'**
>
> *Participant 2*

None of those interviewed accessed peer support; however, one participant did suggest that having someone with comparable experience could have proven beneficial to discuss the treatment:

> **'It would have been nice to speak to someone who had been there, and they can tell you the good and bad about it.'**
>
> *Participant 7*

Professional support

The relationship with their multidisciplinary team (MDT) was fundamental to an individual's progress. Members of the team provided important practical and emotional support. Specifically there was a strong appreciation of the role that the clinical nurse specialist (CNS) played in their treatment trajectory:

> **'I knew I could phone to make an appointment to come and see the CNS … she listened to me and got to know me … she definitely got me through it.'**
>
> *Participant 2*

According to Participant 1, having timely access to the CNS and knowing that support was available when required, was an important element of reassurance:

> **'I could pick up the phone anytime and I knew that [the CNS] would ring me back … the backup was absolutely superb.'**
>
> *Participant 1*

However, other participants felt that there were aspects of support that were missing from important stages of their trajectory, such as when they were first diagnosed. Reflecting on how bad news had been delivered, one participant recalled the poor management of the diagnostic stage:

> **'They pulled me in and some guy who I had never met before sat me down and said, "you've got an operable cancer".'**
>
> *Participant 3*

The lack of support and information at a diagnosis consultation had left Participant 4 feeling like they were a mere statistic:

> **'I was being fobbed off and nobody was telling me anything … you just keep thinking you are only a number.'**
>
> *Participant 4*

It was noted that the CNS had not been present at either of these participants' diagnostic consultations.

Theme 4. Conquering the summit

Within this theme, subthemes of winning the lottery and experiencing personal growth emerged.

Winning the lottery

Participants described the relief and delight of conquering rectal cancer as akin to 'winning the lottery'. They highlighted the contrast between feeling trapped by illness and the extraordinary sense of good fortune and a fresh start in life after overcoming rectal cancer:

> **'I can honestly say it was like winning the lottery. I think it was like being born again. Being able to think I can live like a normal person … go to work, go to the pictures, go shopping, eat any time of the day … it was like a prison sentence that was never ending.'**
>
> *Participant 2*

Others expressed gratitude for their second chance at life:

> **'I'm just lucky to be alive really.'**
>
> *Participant 4*

> **'I feel absolutely great … I feel lucky to be here.'**
>
> *Participant 6*

Personal growth

The firsthand experiences of cancer by participants significantly altered their perspectives. They embraced life fully, living in the moment and shedding the fear of cancer's return:

> **'I have had all that done and it's gone, if it comes back, it comes back.'**
>
> *Participant 3*

Others adopted a more cautious approach, appreciating every day without fear of what might come:

> **'I am feeling fine. The only thing I would say now is that I appreciate every day as you don't know what is around the corner.'**
>
> *Participant 5*

Participants felt less burdened by cancer worries, becoming more positive and emphasising the importance of enjoying life over material possessions:

> **'[I am] much more positive, I don't sweat over small stuff and if I don't like something I change it … money is not everything.'**
>
> *Participant 6*

One participant expressed a newfound appreciation for life and a more relaxed attitude, focusing on seizing opportunities and enjoying life experiences:

> **'I am a lot more relaxed than what I was … I'm thinking well maybe I shouldn't be here, maybe I should be dead, and "He" has given me another wee chance so just make the most of it … that's why I jacked in work and well you don't need money because it doesn't matter.'**
>
> *Participant 4*

Discussion

This study aimed to gain insight into the experiences of individuals diagnosed with rectal cancer and gain an understanding of their treatment trajectory. Drawing from interviews with seven individuals four key themes emerged: uncovering the inner battles, navigating the physical challenges, anchors of support and conquering the summit. These themes collectively emphasise the complex and prolonged impact of treatment on those with rectal cancer (Moran et al, 2017), demonstrating the challenges.

Resonating with previous findings (Pape et al, 2021), the psycho-emotional impact of living with a stoma during treatment was a salient finding. Individuals experienced fear, anxiety, depression and isolation (Han et al, 2020). Despite preoperative teaching and ongoing support from the CNS, they struggled to cope with the presence and management of their stoma after surgery. This finding emphasises the challenges of adapting to altered circumstances and the need for improved information, advice and counselling to help individuals adjust to their new realities. Additional services such as access to peer support, charitable organisations and written information have been recommended as some of the potential support solutions that can contribute to the mitigation of emotional distress associated with rectal cancer. Taylor and Morgan (2011) highlighted the important role of gaining an insider's perspective via a buddy system whereby individuals undergoing rectal cancer treatment can converse with peers who have undergone similar treatment. Additionally, access to 'cancer navigators' can assist individuals across the full treatment pathway, including responding to questions, helping them to understand their treatment, directing them to correct information and support provided by other organisations (Bordonada et al, 2020; Loo et al, 2022). Cancer navigators can be nurses or another member of the multidisciplinary cancer clinical team such as a nursing support worker. Cancer navigators can also be non-clinical members from charities who complement the work of the clinical teams and cancer nurse specialists, as is the case with Macmillan cancer navigators.

The impact of rectal cancer treatment had contributed to ideas of suicide for three individuals, a finding that aligns with existing literature indicating an elevated suicide risk among cancer patients (Kolva et al, 2020). Samawi et al (2017) reported a higher risk of suicide among CRC patients compared with the general population. Moreover, there is a link between suicide contemplation and the diagnostic stage of cancer as sufferers adopt this strategy as a means of regaining control over their lives (Amiri and Behnezhad, 2020). In this study, however, suicidal ideas were attributed to the struggles of coping with treatment rather than the actual diagnosis of rectal cancer. Participants emphasised the profound impact of treatment-related challenges such as dealing with the side effects of adjuvant therapy, and management of their stomas. Given the profound toll of the disease to push individuals into extreme states, these insights highlight the importance of comprehensive psychological and emotional support integrated into rectal cancer care to address not only the medical aspects of treatment but also the mental health and wellbeing of individuals.

Individuals who underwent adjuvant therapy endured various adverse physical side effects affecting their daily lives such as gastrointestinal issues, respiratory difficulties, lethargy and disturbed sleep patterns (O'Gorman et al, 2014; Han et al, 2020). The intensity and severity of these side effects fluctuated across treatment cycles. Findings resonated with previous research (Saunders et al, 2021), where concerns were voiced about sexual wellbeing and maintaining intimacy.

Furthermore, this study highlighted the physical repercussions of Papillon therapy. Generally administered to those unfit for surgery or who are stoma averse, Papillon therapy is a type of radiation-based treatment used to manage rectal cancer that is administered via the insertion of an applicator into the anus (Myint et al, 2023; Cancer Research UK, 2023b). In addition to the common side effects of pain and discomfort, this study highlighted a deeper level of physical distress stemming from the invasive nature of this therapy. Comparing the invasive experience to a profound physical violation, this finding offers a poignant insight into the distinctive challenge that individuals undergoing Papillon therapy may encounter. Given this observation, the implications of Papillon therapy should be an integral part of treatment preparation. Providing tailored psychological support, counselling and interventions by health professionals is a critical component in helping to mitigate and pre-emptively address the potential physical distress that may accompany Papillon therapy.

Both personal and professional support played a pivotal role in rectal cancer, echoing previous research (Rutherford et al, 2020). Family, friends and caregivers provided vital personal support while health professionals including CNSs contributed to the overall support system (Pape et al, 2021). Adding to earlier findings from Saunders et al (2021), the study emphasised the significance of continuously strengthening and expanding support structures in healthcare systems, addressing not only the medical aspects of treatment but also the psychosocial wellbeing of patients.

The concept of survivorship in cancer research holds profound significance in this study. Survivorship encompasses living with, through and beyond cancer, addressing the challenges and opportunities encountered in the aftermath of diagnosis and treatment (Doyle, 2008). Mullan (1985) contextualised cancer survival as a continuum, beginning with diagnosis and extending beyond treatment completion, reflecting 'the survivor's journey' towards remission and an eventual sense of being cured. The enduring impact of cancer, however, remains evident, affecting survivors physically, psychologically and socially. Survivorship in this context encompasses the comprehensive wellbeing of individuals beyond diagnosis and treatment, addressing the myriad challenges and opportunities encountered in the aftermath (Strasser, 2021).

This study suggests that testament experiences can lead to a transformative shift in perspective, empowering individuals to reprioritise their lives and find meaning in their path to recovery. Despite the psychological impact, those interviewed embraced the imperative of making the most of each moment, a sentiment echoing the principles of permanent survival (Mullan, 1985). Highlighting the potential for personal growth and a deeper

appreciation of life, this study sheds light on the resilience and adaptability of individuals coping with rectal cancer.

Strengths and limitations

The study's strengths include its research design, which enabled the exploration of individuals' firsthand experiences, but it acknowledges limitations such as the small sample size and that the sample consisted solely of white middle-aged men and women aged over 40 years, and recall biases. Although the study did not aim for generalisability, the authors recognise the need for diverse perspectives. Given that the incidence of rectal cancer is higher among those aged 50 years and above, it could be that the experiences of younger individuals or those from ethnic or culturally diverse backgrounds may be different.

Conclusion

There has been a notable increase in rectal cancer survival rates in recent decades that generally have been due to advancements in screening, diagnostics, and treatment modalities. The trajectory towards recovery, however, is not without profound tolls. This study provides an insight into the multifaceted impact of rectal cancer on individuals, shedding light on the challenges they confront, the support networks they rely upon and their journey towards survivorship and a redefined perspective on life. It highlights the psycho-emotional impact of rectal cancer treatments, including a range of intense emotions from initial fear, anxiety and, on occasions, suicidal ideation, to the latter stages of acceptance and hope. Equally impactful are the physical challenges that arise during and after treatment, as individuals navigate the arduous terrain of chemotherapy and radiotherapy side effects, as well as the implications of surgery and stoma formation. Crucially, the outcomes of support systems, both personal and professional, play a pivotal role in shaping the experiences of those affected by rectal cancer treatments. This study emphasises the need for a comprehensive support system that addresses psychological, emotional and physical challenges. **BJN**

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KEY POINTS

- Colorectal cancer is the fourth most common cancer in the UK with an estimated 42 886 people diagnosed each year
- Improved survival rates have been linked to early detection, diagnostic procedures, treatment strategies and post-treatment monitoring
- Individuals experience a number of adverse effects because of rectal cancer treatments that impact on their daily functioning
- Addressing the psycho-emotional impact of rectal cancer treatment on the holistic wellbeing of individuals should become a priority
- Professional support from multidisciplinary team members, including the clinical nurse specialist, plays a critical role in supporting patients throughout their cancer trajectory

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CPD reflective questions

- Reflect on the psycho-emotional impact of rectal cancer treatment on the holistic wellbeing of patients. What specific interventions could you adopt to provide psycho-emotional support to your patients?
- How much do you know about Papillon therapy? Consider what measures you can take to develop your understanding of this technique
- Is there scope to use the knowledge gained from the four themes identified in this study to the specialty that you work in? How would you apply this?
- Consider what your multidisciplinary team could do differently to better support your patients through their cancer journey

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