PS1-28:

Rectal Cancer Survivors with Ostomies and Anastomoses: Effects of Cancer Surgery on Perceived Financial Burden and Employment

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Background/Aims: Rectal cancer surgery includes a colostomy (or ileostomy) or, more frequently, anastomosis of the rectum. Both surgery types may create long-term after-effects. We examined differences reported between survivors with ostomies versus anastomoses regarding levels of work, volunteering, and financial burdens, and how much they perceived their cancer operations affected these experiences. **Methods:** We mailed questionnaires to 1,063 rectal cancer survivors (5+ years post-diagnosis) in Kaiser Permanente (Northern California, Northwest) during 2010-2011. We asked about current employment status and the impact of their cancers on labor force participation, demotions, job discrimination, forced retirement, volunteering, social activities, and marital status. Our overall response rate was 60.5% (578/955). We analyzed usable responses from 390 survivors with anastomoses (69%) and 178 survivors with ostomies (31%) for differences in self-reported functional health status, work, volunteer, and perceived financial burden. **Results:** Survivorship ranged from 5 to 25 years. Mean ages for both groups were significantly beyond retirement age (anastomoses = 72 years, colostomies = 74 years) (NS). 56% of patients with anastomoses were male compared to 66% of ostomates (P <0.03). About 35% of all survivors were not married or partnered at time of survey. Survivors with anastomoses were more likely to be currently working (FT+PT=33% (128/383)) than survivors with colostomies (FT+PT=20% (35/178)), while survivors with ostomies were more likely to be retired or homemakers (77% (137/178) vs. 64% (247/383) or on Disability (ostomies = 3.4% (6/178), anastomoses = 2.1% (8/383)) (P <0.01). Stage at diagnosis was not associated with employment or volunteer activities among survivors, but employed survivors had significantly shorter survivorship periods than non-working survivors (P <0.05). Compared to survivors with anastomoses, survivors with ostomies reported significantly higher perceived financial burden from their cancer and its treatment (P <0.001). Permanently disabled survivors reported even higher perceived financial burden than non-disabled survivors, with no differences by ostomy and anastomosis status. **Conclusions:** Compared to survivors with ostomies, survivors with anastomoses were more likely to report being currently employed/working in the home and having lesser financial burdens from their illness. Interventions are needed to support survivors with ostomies to participate in work and volunteer activities, to manage their personal finances, and to maintain their social networks and personal relationships.

Keywords: Rectal Cancer; Survivorship; Colostomy

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PS1-37:

Caregiving, Mutuality, and Long-Term Cancer Survivorship: The Case of Colorectal Cancer Patients with Ostomies

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Background/Aims: The literature on informal caregiving for cancer survivors focuses on the first phases of cancer survivorship, with little evidence on long-term issues. For those whose cancer creates on-going disability, caregiving can continue for decades. Mutuality, the positive quality of the relationship between caregiver and care receiver, can affect acceptance and level of caregiving as well as patient and caregiver outcomes. Because many colorectal cancer (CRC) patients with ostomies have ongoing caregiving needs, understanding mutuality in caregiving relationships in this population is a high priority. **Methods:** We conducted an ethnographic study in two Kaiser Permanente regions with a population-based sample of 31 long-term (>5 years) CRC survivors with ostomies who received informal caregiving; survivors' primary informal caregivers also participated. Eligible survivors received at least one hour of unpaid help a week to help complete tasks that were difficult because of their health. We used in-depth interviews and observations to collect data, and standard qualitative methods for data analysis. **Results:** Most survivors were >71 years old, female, had some college education, and required help with activities of daily living. Two-thirds lived with and received care from spouses. Survivors required help with ostomy care mainly due to stoma-related hernias, poor vision, obesity, poor dexterity, cognitive impairment, and weakness. Caregiving ranged from minimal support to assistance with daily ostomy care. Some survivors received caregiving far beyond what was needed, while others did not receive caregiving that was medically indicated. Low mutuality created challenges for ostomy caregiving. Levels of mutuality ranged from resentful performance of duty-bound aid to an extension of love and commitment. **Conclusions:** Our results support previous findings that cancer diagnoses can enhance high mutuality relationships and diminish low ones. Current findings extend research to include long-term colorectal cancer populations. We found that high mutuality allowed dyads to cooperate with ostomy care tasks that were objectionable to those dyads with low mutuality. For survivors with long-term caregiving needs, care planning should assess, identify, and support mutuality as a resource to enhance quality of life and adaptation over time.

Keywords: Cancer survivorship; Caregiving; Ostomy

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PS1-38:

Colorectal Cancer Survivors' Trust in Their Follow-Up Care Physician: The Role of Patient-Physician Communication by Stage of Cancer

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Background/Aims: Trust in physicians plays an important role in facilitating cancer patients' adjustment to their illness. However, patient trust has rarely been examined within the context of post-treatment follow-up care. We used data from the Assessment of Patient Experiences of Cancer Care (APECC) study to evaluate predictors of colorectal cancer survivors' trust in their follow-up cancer care physicians overall and by stage of cancer. **Methods:** Our analytic sample included colorectal cancer survivors who were 2-5 years post-diagnosis and saw a follow-up care physician in the past year (n = 371). Trust was assessed using a validated 11-item scale and responses were transformed to a 0-100 metric. Hierarchical linear regressions were conducted to examine predictors of trust with socio-demographic, clinical, and follow-up care variables entered in the first model and patient-physician communication variables (i.e., physician knowledge of the patient, information exchange, and physicians' affective behavior) in the second. Using American Joint Committee on Cancer (AJCC) stage classification, stratified regressions were conducted to assess differences in predictors of trust by early (0, i, ii) vs. late stage (iii, iv) patients. **Results:** The mean trust score was 83.58 and did not significantly vary by cancer stage. In the main effects model, older age, increased length of patient-physician relationship, better health status, and male physician gender were associated with greater trust (P <0.05 for all). When communication variables were added, physician knowledge (P <0.001), information exchange (P <0.001), and affective behavior (P <0.05) were significantly associated with greater trust. In stratified analyses, physician knowledge (P <0.001) and information exchange (P <0.05) were associated with greater trust among early stage patients and information exchange (P <0.001) and physician affect (P <0.05) were significant predictors of trust among late stage patients. **Conclusions:** Patient-physician communication plays a central role in facilitating trust between colorectal cancer survivors and their follow-up care physicians. Information exchange was an important dimension of communication for all survivors, but early stage patients valued physician knowledge while late stage patients valued physician affect. Our findings suggest that to build and sustain patient trust, different aspects of communication may need to be emphasized during follow-up care interactions between physicians and survivors diagnosed with early vs. late stage colorectal cancer.

Keywords: Trust; Follow-Up Care; Patient-Provider Communication

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