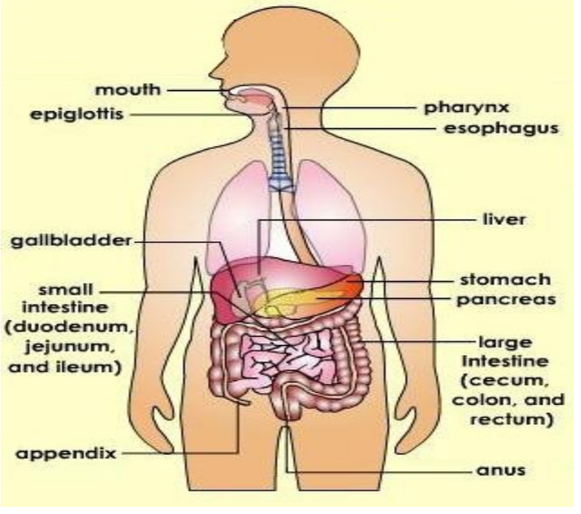
CHAPTER 2
THEORITICAL BACKGROUND

2.1 Concept Disease

2.1.1 Anatomy And Fisiology



Picture 2.1 Anatomy and Fisiology

(Source: sridianti, 2013)

2.1.1.1 Mouth

Inside the mouth there are teeth, tongue, and digestive glands. These digestive organs serve to digest food mechanically and chemically.

a. Teeth

Human teeth consist of incisors, fangs, grahams. The series teeth are located on the front shaped like an ax, which has a function to drive the food. In addition to the incisors, there are teeth tarinThese canine teeth are pointy and useful for tearing food. Behind the canine teeth there is a molars that have a function to smooth the food (Ardiansyah, 2012).

b. Tongue

Tongue is useful to help set the location of food in the mouth and push food into the esophagus. In addition, the tongue also serves to taste or taste the food. On the tongue, there are sensitive areas to certain flavors, such as salty, sour, sweet, and bitter (Ardiansyah, 2012).

c. Salivary

Salivary Glands are produced by three pairs of salivary glands, namely the parotid salivary gland, salivary glands, and salivary glands under the tongue. The spit produced then flowed through the saliva channel that empties into the oral cavity. saliva contains water, mucus, salts and

enzymes. enzyme functions to convert starch into sugars, namely maltose and glucose (Ardiansyah, 2012).

2.1.1.2 Esophagus

From the mouth, the food goes into esophagus. The esophagus is a long channel as a food path from the mouth to the stomach. The length of the esophagus is approximately 20 cm with a diameter of approximately 2 cm. The esophagus can widen, narrow, wavy, and squeeze-squeeze forpushing food into the stomach. Such motion is called peristaltic motion. In the esophagus, food does not undergo digestion. At the front of the esophagus, there is breathing called the trachea. This trachea serves to connect the nasal cavity with the lungs. By the time we swallow the food, there is a bone that covers the hole to the throat. The part is called epiglottis, which prevents the food ma from entering the lungs (Ardiansyah, 2012).

2.1.1.3 Stomach

Stomach is a pouch located in the left abdominal cavity, under the partition of the body cavity. The stomach can be divided into three areas, namely the cardia, fundus, and pylorus area.

Explanation of the stomach below as follow :

a. Cardia is the top, can be likened to the food entrance area of esophagus.
b. Fundus is the middle, rounded shape.
c. The pylorus is the lower part, the area associated with the 12 finger gut (Ardiansyah, 2012).

2.1.1.4 Small intestine

The small intestine is the longest digestive tract consisting of three parts, namely duodenum, jejunum, and ileum. Intestine Finger This part of the intestine is called the twelve fingers because of the length of about 12 fingers parallel to each other. Inside the intestinal wall of the twelve fingers, there is a common channel estuary of the gallbladder containing bile. Liquids produced by the liver is useful for emulsify fat. Bile is greenish and bitter taste. The pancreas lies below the stomach and produces the sap of the pancreas. This pancreas sap contains enzyme amylase, tripsinogen, and lipase. Amylase converts starch into sugar. Tripsinogen is an active enzyme but can be activated first by the enzyme enter okinase produced by the small intestine Enzyme enterokinase convert trypsinogen into an active trypsin. Tripsin converts proteins into peptides and amino acids. Lipase change digestive substances are easily

absorbed by the intestinal wall through the process of diffusion and osmosis. Substances that have not been described can enter the intestinal cell membrane through active transport (Ardiansyah, 2012).

Empty Intestine The length of the empty intestine is between 1.5 to 1.75 m. In this intestine, food undergoes chemical digestion by enzymes produced by the intestinal wall. The empty intestine produces intestinal sap containing mucus and various enzymes. Enzyme enzymes can break down food molecules become more simple. Inside this gut, the food becomes a creamy mush and porridge (Ardiansyah, 2012).

2.1.1.5 Colon, Rectum, and Anus

The large intestine or colon is a continuation of the intestine. The length of the large intestine more or less one meter. The boundary between the intestine with cecum is called colon (cecum). Appendicitis bowel called having an additional Appendix (Appendix). Inflammation of the bowel is extra is called to appendicitis and is often referred to as the intestinal pain dead end. The large intestine is composed of part of the intestine that is horizontal, ascending, and descending colon is the primary function of regulating the water content the rest of the food. If the moisture content is contained in the rest of the food excess, the excess water is absorbed by the large intestine. Conversely, if the rest of the food shortages of water, it will be given extra water. In the colon, there are bacteria decomposing Escherichia coli which act to decompose food scraps into dirt. Thus, dirt becomes soft and easily removed. These bacteria generally do not interfere with human health, there are even several types of bacteria that produce vitamin K and certain amino acids that are useful to humans.

The end of the colon is called the intestinal axis (rectum). The length of the rectum is approximately 15 cm and empties into the anus. Anus has two kinds of muscles, namely the unconscious muscles and conscious muscles. By the time food reaches the rectum, all useful substances have been absorbed into the blood, while the rest are inactivated foods, bacteria, and dead cells from the digestive tract of food. The mixture of these ingredients is called feces. Various diseases can enter the body through the digestive system of food. This means that food hygiene and health must be maintained (Ardiansyah, 2012).

2.1.2 Definition

Cancer is a disease caused by the growth of cells of body tissue that is not normal. Cancer cells will develop rapidly, out of control, and will continue to divide. Furthermore, cancer cells will infiltrate the surrounding tissues invasive and continue to spread through connective tissue, blood, as well as attacking important organs and spinal cord (Indah, 2010).

Colorectal cancer is a malignant tumor that appears on the epithelial tissue of the colon or rectum. Generally, colorectal tumors are adenocarcinomas that develop from polyp adenoma (Wijaya. A.S, 2013).

Colon cancer is a form of malignancy from abnormal periods or neoplasm arising from the epithelial tissue of colon (Haryono. R, 2012). Colon cancer is a malignant tumor consisting of epithelial from the colon or rectum (Suratun & Lusinah, 2014).

colorectal cancer (colo-rectal carcinoma) or also called colon cancer is a malignant tumor found in colon or rectum. One way to detect colorectal cancer is by examination using colonoscopy. After colorectal cancer is detected classification to determine the stage of cancer. In this study used the Recurrent Neural Network (RNN) model for colorectal cancer stage classification. This study aims to explain the procedure and level of accuracy of RNN modeling of eleman tissue in colorectal cancer stage classification of photo colonoscopy (Setianingrum, 2014).

Laparatomy is one of the major surgical procedure by perform ablation on the abdominal wall to get abdominal organ with problem, suchas cancer, bleeding, obstruction and perforation (Sjamsuhidajat. et al, 2010).

Chemotherapy is a drug used to treat cancer by destroying abnormal cell or slowing the growth (Nguyen, 2018).

2.1.3 Etiology

The cause of colon cancer are not know for certain, but there are several risk factor that are suspected of causing colon cancer, including age 40 year, history of rectal polyp or colon polyp, or presence polyp adematosa and adenoma villus. In addition, family history with colon cancer or polyposis in the family, or a history of chronic inflammatory bowel disease may be a risk factor (Mardalena, 2018).

Food containing chemicals suspected of causing cancer in these food reduce circulation time in the stomach and accelerate the work of the large intestine. High-fat food, especially animal fats from red meat can

cause the secretion of anaerobic acid and bacteria, and cause colon cancer. Fried and fried meat can also contain chemical that trigger cancer (Mardalena, 2018).

The carbohydrate diet is the diet contain high fiber and reduce circulation time in the colon. Diet with little animal fat and high vegetables and fruit are often recommended to avoid the risk of cancer colon. Some food that should be avoid are red meat, animal fat, fatty food, meat and fried or grilled fish, and filtered carbohydrate. Meanwhile, food that should be consummed more often are fruit and vegetables, especially from cabbage groip such as broccoli and cabbage. Whole grains and sufficient fluid intake, especially water, help maintain health bowel health (Mardalena, 2018).

The risk of cancer colon will be 2/3 times greaterif a family member sufferes from the disease. Meanwhile, the risk of cancer in polyposis is close to 100% of people suffer from ulcerative colitis or crohn's disease also have a risk of colon cancer (Mardalena, 2018).

2.1.3.1 Chemicals (carcinogens) Materials included in the carcinogenic include asbestos cigarette, and alcohol In addition, excessively processed foods, such as fried foods in re-treated oil bath, smoked, baked in the form of food containing taste buds, preservatives or food contaminated with hazardous metals such as mercury in seafood (Indah. Y., dkk, 2010).

2.1.3.2 Exposure to ultraviolet (UV) rays Exposure to radiation rays of violet (UV) , especially between 10:00 to 14:00 can cause skin burning Permanent damage to the skin and eyes in the long term potentially cause skin cancer (Indah. Y., dkk, 2010).

2.1.3.3 Tension or Stress Some research has shown that chronic stress can weaken a person's immune system which can eventually become one of the trigger factors of cancer such as sarcoma and some types of lymphoma (lymphoma cancer). Other studies have shown that stress also negatively affects endocrine hormone release, the hommon that regulates DNA repair and regulates cell growth Well, from now on no more burden yourself with a tension (Indah. Y, dkk., 2010).

2.1.3.4 Genetic Factors About 5-10% of cancer cases are inherited diseases. In certain families, abnormal genes can be inherited Types of inherited cancers in the family such as breast, ovarian, prostate, or colon (colon) (Indah. Y, dkk., 2010).

2.1.4 Signs and Symptoms

2.1.4.1 In general: change in the habit of defecation, blood in the stool, abdominal pain, anorexia, flatulence and can not digest food.

2.1.4.2 Advenced symptoms: weight loss, fatigue, decreased health

2.1.4.3 Clinical manifestation based on the location of cancer (lesion):

a. Right side lesion: superficial, obscured pain in the abdomen that spread to the back, dark red blood in the stool, weakness, anemia, ma-laise, can not digest, weigh loss and liquid feces.
b. Left side lesion: change in defecation habit, cramps, pain, decreased fecal size, bright red bleeding, constipation, rectal pressure and incomplete defecate
c. Transverse colon: palpable masses, obstruction, change in defecation habits and bloody stools.
d. Rectal: Change in the habit of defecation, bright red bleeding, tenes of the mus, severe pain in the groin, labia, scrotum, leg or penis (Suratun & Lusinah, 2014).

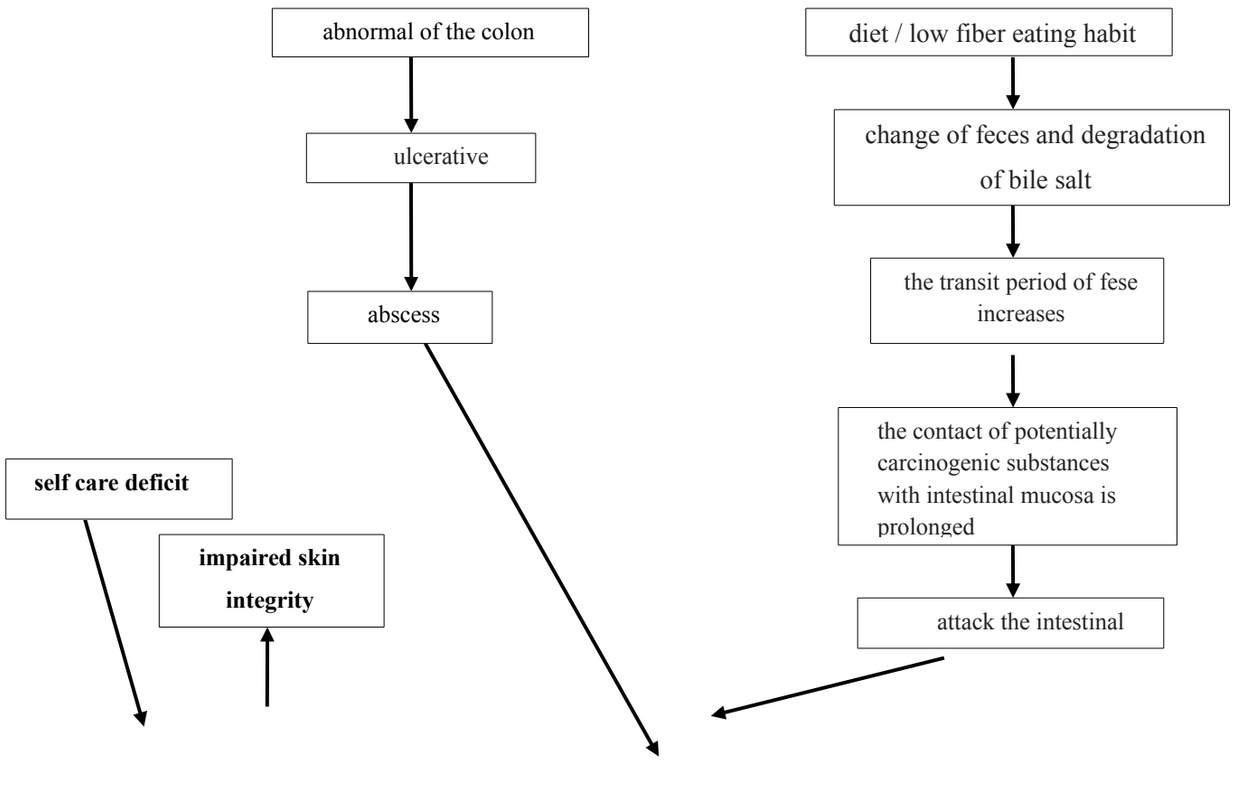
2.1.5 Pathophysiology

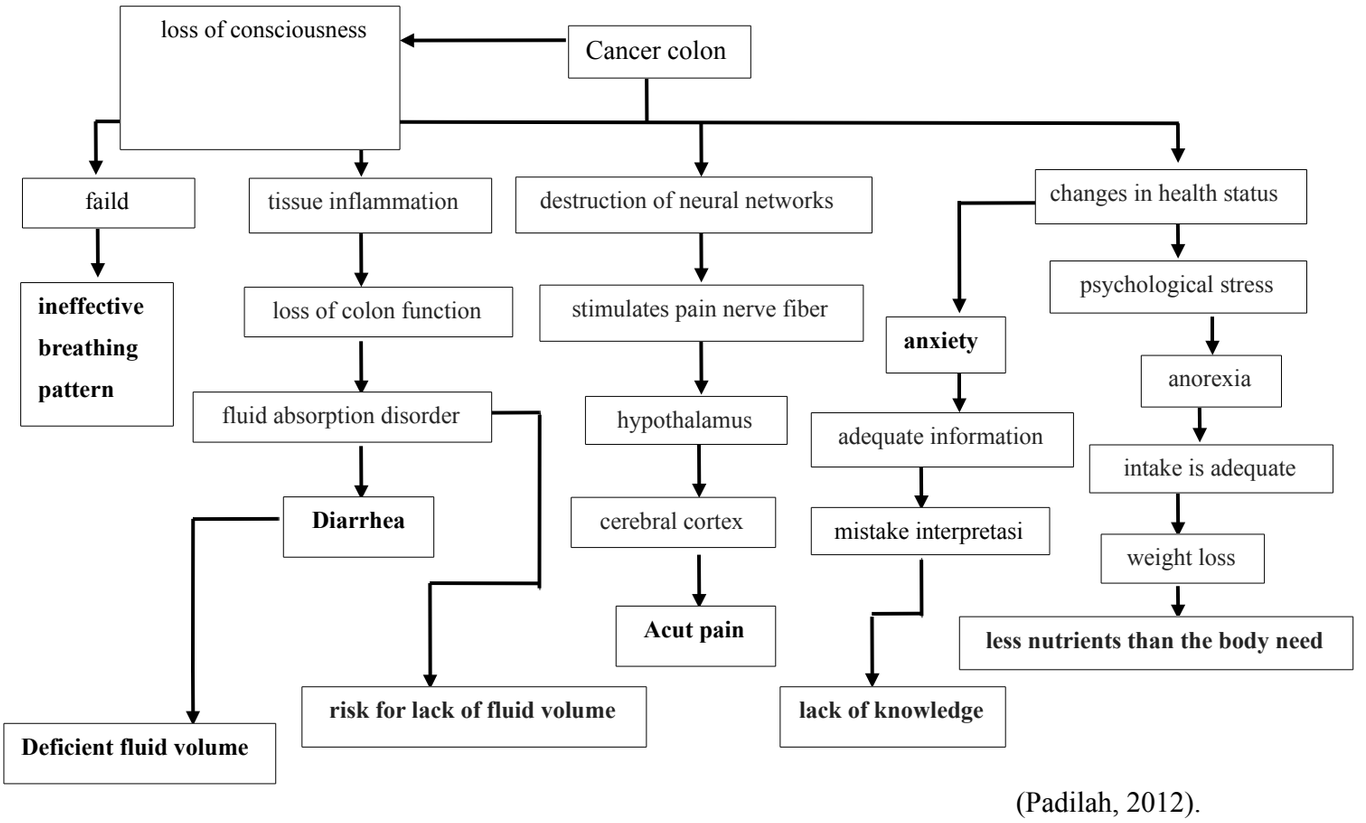
The cause of cancer colon is not know for certain, but food is considered the gighest risk factor, especially cholestrol food and high animal fat content, low fiber content, and the interaction between bacteria in the colon with bile acid and food. In addition, alcohol beverages, especially beer are also suspected of causing cancer colon. Colon and cancer rectal are typically histopathologic (95%) in which adenocarcinoma arises from the epithelial lining in the gut (endothelium). The apperence of a tumor usually begins as a benign polyp that can then become malignant and infiltrate and destory normal tissue and extend into the surrounding structure. Tumor may be polypolid period, large grow into the lumen, and rapidly extend into the vicinity of the intestine as annular strictures are common in the rectosigmoid, whereas flat polypoid lesion are more common in as and ascending tumor colon can spread by:

2.1.5.1 Direct infiltration to adjacent structure, such as into the bladder (vesikaurinaria).
2.1.5.2 Spread through lymph vessel, lymphogen to pericolon lymph nodes and mesocolon.
2.1.5.3 Through the bloodstream, hematogen usually lead to the liver because the colon drain the blood back to the portal sytem.

2.1.6 Pathway

2.2 Picture





(Padilah, 2012).

2.1.7 Diagnostic Examination

2.1.7.1 Endoscopy. Examination endoscopy need to be done, either sigmoidoscopy or colonoscopy. picture typical features of karsi-noma or ulcers can be seen clearly through the endoscopy, and to make the diagnose biopsy is necessary (Mardalena, 2018).

2.1.7.2 Radiology. possible radiological examination include chest and colon photographs (beriumanema)

2.1.7.3 Examination with barium enema may be able to clarify the tumor state and identify the site this test may reflect an impending stomach content, in which there is a reducting in tumor size in the lumen. Minor injuries are unlikely to be identified with this test. Barium enema is generally performed after sigmoidoscopy and colonoscopy.

2.1.7.4 Computer tomography (CT) help to clarify the mass and extent of the disease. Chest Xray and liver scan may be able to locate metastatic sites this examination is also be used for preparation

of surgery. In the colon image can be seen a *Filling defect* in a place or a stricture.

2.1.7.5 Ultrasound (ultrasound). This examination is useful to detect the presence or absence of metastatic cancer of lymph nodes in the abdomen and in the.

2.1.7.6 Histopathology / In addition to endoscopy should be done biopsy in some places for histopathologic examination to make the diagnosis. The histopathological features of colorectal carcinoma are adenocarcinoma and need to be determined by cell differentiation.

2.1.7.7 Laboratory examination. There are no markers typical for colon cancer, however any patient who has bleeding needs Hb examination. Tumor marker (tumor marker) commonly used is CEA. CEA levels greater than 5 mg / ml are commonly found in advanced stage colon cancer. Based on the CEA study study can not be used for early detection of colon cancer, because titer is found in excess of 5 mg / ml in only one third of stage III cases. Patients with bloody mucous bowel movements should be examined for bacteriological stool against shigella and amoeba.

2.1.7.8 Scans (eg,MR) and ultrasound are performed for diagnostic purposes, metastatic identification, and response evaluation on treatment.

2.1.7.9 Biopsy (aspiration, excision, needle) is performed for diagnostic appeal and describes treatment and can be done through bone marrow, skin, organs and so on.

2.1.8 Management

2.1.8.1 Medical Management

Patient with intestinal obstruction symptoms are treated with IV fluid and nasogastric suction. In the event of significant bleeding, blood component therapy may be given. The most common medical treatment for colon cancer is in the form of support or adjuvant therapy. Speech therapy is usually given in addition to surgical treatment. Options include chemotherapy, radiation therapy and or immunotherapy (Mardalena, 2018).

2.1.8.2 Surgical Management

Surgery is the primary action for most colon and rectal cancers. Surgery can be curative or palliative. Cancer that is limited to one side can be removed with a colonoscope. Laparoscopic colostomy with polypectomy is a newly developed procedure to minimize the extent of surgery in some cases. Laparoscopes are used as guidance in making decisions in tumor mass colon then excised. intestinal section is indicated for most class

lesions Adan all lesions class B. Surgery is sometimes recommended to treat class D colon cancer. The purpose of surgery in this situation is palliative If the tumor has spread and covers the surrounding vital structures, surgery can not be performed. The type of surgery depends on the location and size of the tumor. Colostomy (making of colonic holes / stomas) is performed in less than one-third of colorectal cancer patients. This stoma can serve as a temporary or permanent dispersion that allows drainage or evacuation of the contents of the colon out of the body (Mardalena, 2018).

2.1.8.3 Nursing Management

a. Adaptation support and independence
b. Increase comfort
c. Maintain optimal physiological function
d. Prevent complications
e. Provides information about disease prognosis process / condition, and treatment needs

2.1.8.4 Management of the Diet

a. Consume more fibrous foods, such as vegetables and fruits. Fiber can digestion and defecate so that it functions to remove dirt and substances that are not useful in the intestines. Dirt that is too long to settle in the intestines will be a toxin that triggers cancer cells.
b. Consumption of beans, about five servings each day.
c. Avoid gfoods that contain saturated fats and high cholesterol especially found in animal flesh.
d. Avoid preserved foods and synthetic dyes, as they can trigger nogenouskarsi cells / cancer cells.
e. Avoid alcoholic beverages and cigarettes.
f. Perform physical activity or exercise regularly (Mardalena, 2018).

2.1.9 Complication

Usually tumors attack the blood vessels and surrounding areas and cause bleeding. The tumor grows into the large intestine and gradually helps the large intestine until it can not altogether. The expansion of the tumor exceeds the stomach and may suppress the surrounding organs, such as the uterus, bladder, and ureter. Complications in patients with colon cancer are :

2.1.9.1 Growth of tumors can cause partial or complete intestinal obstruction.

2.1.9.2 Metastase to surrounding organs, through hematogen, lymphogen and direct spread.

2.1.9.3 Growth and ulceration may also invade the blood vessels surrounding the colon causing hemorrhage.

2.1.9.4 Perforation of the intestine may occur and result in the formation of abscess

2.1.9.5 Peritonitis and or sepsis may cause shock.

2.1.9.6 Formation of the abscess
2.1.9.7 Formation of fistulas in the urinary bladder or vagina (Mardalena, 2018).

2.2 Basic Concept of Nursing Care

2.2.1 Nursing Care

Assessment that can be done according to (Wijaya and putri, 2013), among other are as follow

2.2.1.1 Assessment

a. Data Demographic
   1. Cancer colon is often found to occur at the age of more than 40 year.
   2. In famale often found cancer colon and cancer rectal more common in male.
b. History of previous disease
   1. Possibility of colon polyp, inflammation colon chronic and unresolved ulcrative colitis
   2. Infection and obstruction of the large intestine.
   3. Diet or consumption of bad diet, high protein, high fat and low fiber.
c. History health of family
   The presence of a family history of cancer, identified cancers that attack the body or organs including colorectal cancer is derived as a dominant trait.
d. History of current disease
   1. Clients complain weak, abdominal pain and bloating
   2. Clients complain of changes in defecation defecation such as ribbons, diarrhea mixed with blood and mucus and dissatisfaction after defecation
   3. Client megalami anorexia, nausea, vomiting and weigh loss.
e. Physical examination
   1. Eyes: conjunctiva lsubanemic or anemis
   2. Neck: distensi jugulans vein (JVP)
   3. Mouth: mucosa mouth dryand pale, tongue is cracked and an unpleasant smell
   4. Abdominal: distension abdomen, the presence of palpable mass, decline bowel sounds and bloating.
   5. Skin: poor, dry skin turgor (dehydration malnutrition)
f. Functional assessment Gordon
   1. Rest or activity
      Symptoms: of weakness, fatigue, malaise, fatigue, anxiety and anxiety do not sleep overnight due to diarrhea restriction of ape activity due to the effects of disease process.
   2. Breath
      Shortness, dispnea (response to perceived pain) characterized by tachypnea and decreased frequency.
   3. Circulation
      Symptoms of tachycardia (respon to fever, dehydration, inflammation and process pain),

hipotensi poor turgor skin or membrane, dry, cracked tongue, (dehydration malnutrition)

4. Integrity Ego
   Symptoms: anxiety, fear, irritated emotion, eg feeling helpless no hope. Factors cut or chronic : such relationship family work, expensive treatment sign: narrow attention, depression.
5. Elimination
   Symptom: Texture fecal vary and soft to smell the episode of blood diarrhea are unpredic table, disappearing often uncontrol table (much as 20-30 time the day of discomfort or dissatisfaction, mucosa detection with or without out fecal.
   sign: decreased bowel sound, no peristaltic or paristaltis visible, oliguria.
6. Eating or Liquit
   Symptoms: anorexia, nausea, vomiting, wiegh loss, intolerance to sensitivity (eg fresh fruit or muscle mass, weakness, muscle tone and skin turgor, pale mucos membran, wound, oral inflammation.
7. Hygiene
   Inibality to perform self care, stomatitis, indicating vitamine deficiency.
8. Musculoskeletal
   Decreased muscle strength, weakness and malaise (Diarrhea, dehydration and malnutrition).
9. Sexuality
   Symptoms: can not have sexual intercourse or frequency decreased.

2.2.2 Nursing Diagnose

2.2.2.1 Acut pain related to secondary tissue compression due to obstruction.
2.2.2.2 Constipation related to lesion obstruction, gastrointestinal irritation mucosa from chemotherpy or radiation
2.2.2.3 Impaired skin integrity related to process surgery
2.2.2.4 Risk for deficient fluid volume related to vomiting and dehydration.
2.2.2.6 Risk for infection related to the existence of surgical wound
2.2.2.7 Lack of knowledge related to disease

2.2.3 Nursing Intervention

According to Suratun & Lusinah (2014), that nursing intervention on with client colon cancer

Table 2.1 Nursing Intervention

	No	Diagnose	Goal	Intervention	Rational
1.		2.2.2.1	After the nursing action for 15 minute is expected pain client can be reduce by the resulth criteria : a. pain is lost or controlled b. the facial expression of the client is relaxed c. client can break with enough	1. Assess history of pain: location, frequency, duration and intensity (0-10 scale), and the removing action used. 2. Explain to the client or person closest what is expected, from the therapy program given: surgery, radiation, chemotherapy. 3. Give basic comfort measures, such as repositioning, rub back) and entertainment activities such as listening to music, watching telavisi. 4. Encourage the use of pain management skills, (relaxation techniques, visualization, imagination guidance), laughter and therapeutic touch. 5. Explain to clients to avoid overheating orcold drinks and spicy foods. 6. Explain that clients avoid activities that stretch the theoretical area. 7. Encourage sitting up straight for 1-4 hours after each meal. 8. Set the sleeping position semifowler or the head of the bed higher 10-20 cm. 9. Explain that clients do not use excessive antacids orwithout a prescription.	1. Identify baseline data to evaluate the needs or effectiveness of interventions. 2. Broad-range discomfort is common, (incision pain, burning skin, lower back pain, headache), depending on the procedure used. 3. Enhance relaxation and help refocus attention. 4. Enable clients to participate actively and improve the sense of control. 5. Because it stimulates the esophageal spasm and increases the secretion of hydroxide acids. 6. Because it can increase pain. 7. To prevent the occurrence of reflux. 8. To prevent the occurrence of reflux. 9. Excessive use of antacids will lead to increased stomach acid and esophageal irritation.
2.		2.2.2.2	After nursing action for 6 hour is expected complaint constipation client can be resolved with result criteria a. maintain a consistency or normal defect pattern b. the consistency of normal feces	1. Assess client's defect habits 2. Assess bowel sounds, frequency of defecation and consistency of feces, especially the first 3-5 days of alkaloid therapy. 3. Monitor fluid input and	1. As a basis for evaluation of the pattern of defecation during treatment. 2. Constipation is one of the manifestations of neurotoxicity. 3. Inadequate fluid intake

		c. normal defect pattern	discharge. 4. Encourage adequate fluid intake between 1-2 liters or day. 5. Suggest eating high fiber 6. Encourage doing range of motion (ROM) exercises passively or actively. 7. Eat little but often with low residual: eggs, cereals, blended vegetables. 8. Explain to clients to avoid foods high in fat and foods with high fiber content. 9. Monitor the results of laboratory tests: appropriate electrolyte program 10. Give intravenous fluids according to the therapy program. 11. Give antidiarrheal therapy. 12. Give fese softener: laxative, enema as per therapy program.	may cause constipation. 4. Can reduce the possibility of constipation. 5. Can improve the consistency of feces. 6. Stimulates intestinal peristalsis, so there is a stimulus for defecation. 7. Low-fiber foods can reduce irritability and rest on the intestine in case of diarrhea. 8. Increases gantrointestinal stimulation that can increase the frequency of defecation. 9. To know the imbalance of electrolyte. 10. Prevent dehydration, dilute the chemotherapy agent so as to reduce side effects. 11. To stop the occurrence of severe diarrhea. 12. Facilitate defecation, especially in clients receiving therapy with constipation side effects.

3.		2.2.2.3	After the nursing action 1 x 6 hour is expected to impaired skin integrity client can be resolved with the resulth criteria : a. good skin integrity can be maintained b. no cut or lesion on the skin c. good tissueperfusin d. able to protect the skin and maintain skin moisture and natural treatment	1. Monitoring the skin will have red marks 2. Change position every 2 hours 3. Perform massage on a prominent area that is under stess when changing position 4. clean and dry the skin keep linen dry 5. Apply lotion or oil or baby oil on depressed area	1. Redness of the skin indicates the occurrence of sking damage 2. Avoiding excess pressure on prominent area 3. avoid damage to capillaries 4. Improve skin integrity and reduce the risk of skin moisture 5. Prevent further decubitus injuries
4.		2.2.2.4	After the nursing action for 1 x 6 hour is expected the risk for deficient fluid volume in the client can be resolved with result criteria : a. indicates adequate fluid balance b. moist mucous membran c. good skin turgor d. fast capillary reffil e. urine intake is adequate.	1. Monitor input (intake) and discharge (output) fluid. Calculate fluid balance every 24 hours 2. Weigh the weight every day. 3. Monitor vital signs, peripheral pulses, and capillary refill. 4. Assess skin turgor and moisture of mucous membranes and thirsty complaints. 5. Encourage increased fluid intake of 2.5-3 liters every 24 hours 6. Observation of bleeding tendencies, eg seepage of mucous membranes: the presence of ecchymoses orpetechiae. 7. Avoid trauma and pressure on the puncture side. 8. Give intravenous fluids according to the therapy program. 9. Limit the food and fluid intake of oral. 10. Give antiemetics according to the therapy program. 11. Installation of nasogastric tube (NGT)	1. Continuous negative fluid balance, decreasing urine expenditure indicates dehydration. 2. Measurements are sensitive to fluctuations in fluid balance. 3. Indicates the intensity of the circulating volume. 4. Indicator of status of fluid deficiency degree. 5. Meet fluid needs and reduce the risk of complications. 6. Early identification of problems that can occur due to cancer or therapy, allowing for immediate intervention. 7. Reduce the potential for bleeding or hematoma formation. 8. To hydrate and dilute antineoplastic drugs and reduce side effects: nausea, vomiting and nephrotoxicity. 9. Can prevent the occurrence of vomiting 10. Eliminate complaints of nausea or vomiting 11. To drain fluid accumulation and

			is performed at the preoperative. 12. Install the indwelling catheter according to the program.	prevent abdominal distension. 12. To enable monitoring of urine expenditure every hour.
5.	2.2.2.5	After nursing action during 1x6 hours, risk for infection problem can be solved, with criteria: a. clients are free from signs and symptoms of infection b. the number of leukocytes within normal limits	1. Check the abdominal incision wound every hour for the first 24 hours. 2. Change the incised bandage according to the program with aseptic technique. 3. Help clients bind or repress the abdominal incision when coughing. 4. Monitor the increase of vital signs (TTV). 5. Check the stoma: the edema, the color, whether there is seepage and bleeding. 6. Peristoma skin is cleaned slowly and dry. 7. Give skin protective barrier before lifting the drainage bag 8. Observe any signs of hemorrhage on the perianal wound and the gradually removed drain or tampon. 9. Do colon irrigation or soak sit 2-3 times a day. 10. Give antibiotics in the post operative period.	1. Identify possible complications of incision wounds. 2. A clean dress prevents the proliferation of microorganisms in the incision wound. 3. Pressure on the incision wound reduces the stress at the edges of the incision, thus reducing the pain during coughing. 4. Increased TTV indicates the occurrence of infection process. 5. Mild edema due to surgery is normal. The color of healthy stoma is pink. Minor seepage is normal. Bleeding abnormal signs 6. Clean and dry conditions in the peristoma area to prevent irritation 7. Protective skin can prevent skin irritation 8. Identify the possibility of complications. 9. Cleans colon and facilitate in cleaning the necrotic tissue in the perianal area 10. Prevent the occurrence of postoperative infections.
6.		2.2.2.6	After the action of 1 x 6 hour is expected to lack client knowledge and family can be resolved with the result criteria : a. Patient and family express understanding of	1. Explain about ostomytreatments and complications that should be observed. 2. Explain about the right diet according to the conditions. 3. Explain the client about	1. The client can understand ostomy treatment and know if complications occur 2. To help clients identify and avoid foods that cause diarrhea or constipation. 3. In order for the client to

		disease, condition, prognosis and treatment program b. Patient and family able to carry out properly described procedure c. Patient and family able to explain back what explained by other nurse or health team	prescribed medication; purpose drug work, and side effects of each drug. 4. Teach clients and families the way irrigation, cleaning and replacement of colostomy. 5. Explain possible complications, bleeding, abdominal distension, diarrhea and dumping syndrome.	know the purpose, the work of the drug and its side effects. 4. In order for clients and families to do wound care at home. 5. In order for clients to know the sign of the occurrence of complications and immediately report to the doctor.