Review Article

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A Systematic Review of Self-Management Interventions for Patients with Colorectal Cancer

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ABSTRACT

Background: Colorectal Cancer (CRC) is a major global health issue and ranks among the most prevalent cancers worldwide. Despite treatment advancements, CRC patients often encounter challenges that negatively impact their QoL, highlighting the need for effective self-management strategies. **Objective:** This systematic review assesses the types, content, and impacts of self-management interventions for CRC patients. **Methods:** A systematic review was conducted, reviewing studies published between January 2013 and February 2022, across nine databases, including JSTOR, Emerald Insight, Oxford Academic, ScienceDirect, SAGE, Clinical Key, ProQuest, Scopus, and Taylor & Francis. The review focused on randomised controlled trials (RCTs) involving self-management strategies for adult CRC patients. Keywords used included "colorectal cancer," "colorectal survivor," "bowel cancer," "colorectal tumour," "colorectal neoplasm," "self-management programme," "self-management training," "self-management intervention," "randomised controlled trial," and "experimental study." Articles were selected based on title and abstract relevance, and findings were synthesised narratively and tabulated. **Results:** The search yielded 668 articles, with nine studies included after screening and bias risk assessment. Interventions varied, lasting from 24 days to 12 months, with assessments conducted 3-4 times. These included psycho-educational programmes, smartphone apps, supportive care, self-help workbooks, access to e-Health resources, and structured pain self-management. Control groups generally received standard care or the same intervention post-study. Outcomes included improvements in self-efficacy, QoL, distress, anxiety, depression, physical activity, adherence to medical advice, symptom management, functional scales, emotional and social functioning, patient competence, social support, and pain management. **Conclusions:** Self-management interventions for CRC patients significantly enhance various health outcomes, underscoring their potential to improve nursing and patient care and QoL.

Keywords: Colorectal Cancer; Patient Care; Self-Management; Systematic Review

INTRODUCTION

Colorectal cancer (CRC) is the third most prevalent cancer globally, accounting for about 10% of all cancer diagnoses and ranking as the second leading cause of cancer-related deaths World Health Organisation (WHO), 2023; Bray *et al.*, 2024). By 2040, CRC cases are expected to rise to 3.2 million, with 1.6 million deaths (Sung *et al*., 2021). Both developed and developing countries, especially those with low and middle economic levels, are experiencing increasing CRC incidence rates, impacting patient health and QoL levels (Arnold *et al.*, 2017; Khan & Lengyel, 2023; Alessy *et al*., 2024). High-incidence countries have reduced CRC rates through healthier lifestyles and improved screening, but globally, the burden remains high, particularly where access to interventions is limited (Bray *et al.*, 2024; Zhou *et al*., 2024). Early screening is crucial, as

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CRC is often asymptomatic in early stages (Liu, Ye & Jia, 2024); American Cancer Society, 2021). Despite treatment advancements, patients continue to face symptoms and the side effects, such as rectal bleeding, bowel changes, weight loss, neuropathy and psychological distress, that impair QoL (Han, Yang & Syrjala, 2020; Gosselin *et al*., 2016; Vlaski *et al*., 2024).

Recognising these challenges, holistic care approaches like nursing led self-management interventions are essential. Effective self-management empowers patients to handle symptoms and lifestyle changes (Barlow *et al*., 2002; Lorig & Holman, 2003; Aryani, *et al*., 2024a). However, many interventions lack personalisation and integration into nursing practice, and inconsistent research makes it difficult to identify best practices (Husebø, Karlsen & Husebø, 2020; Aryani *et al*., 2024b; Aryani *et al*., 2023). Barriers to self-management persist, requiring tailored strategies and innovative approaches, such as digital health solutions, to improve engagement and outcomes. Despite growing literature, no recent systematic review has comprehensively mapped and critically appraised the range of self-management interventions for CRC patients, particularly considering new digital personalised approaches. This review uniquely integrates traditional and technology-enhanced strategies, focusing on effective components for diverse patient groups. By synthesising current evidence, we aim to propose a conceptual framework to guide tailored, patient-centred nursing interventions. This systematic review aims to bridge the gap by (1) identifying self-management approaches for CRC patients and (2) evaluating their effectiveness. By highlighting key strategies, we seek to provide evidence-based recommendations for healthcare providers and policymakers.

METHODOLOGY

Design

This systematic review followed the Cochrane Handbook (Higgins *et al*., 2024) and PRISMA guidelines (Page *et al*., 2021).

Search Methods

A comprehensive search was conducted across nine databases (JSTOR, Emerald Insight, Oxford Academic, ScienceDirect, SAGE, Clinical Key, ProQuest, Scopus, and Taylor & Francis) using keywords related to "colorectal cancer" OR "colorectal survivor" OR “bowel cancer" OR "colorectal tumour" OR "colorectal neoplasm"; "self-management programme" OR "self-management training", OR "self-management intervention"; and "randomised controlled trial" OR "experimental study". Titles and abstracts were screened using content analysis to identify relevant articles.

Inclusion and Exclusion Criteria

Studies were included if they: (1) involved adults (>18 years) undergoing primary CRC therapy, (2) used self-management intervention, (3) were RCTs published in peer-reviewed, open-access journals from January 2013-February 2022, (4) were in English, and (5) provided full text. Excluded were encyclopaedia, book chapters, conferences, correspondence, editorials, news, practice guidelines, protocols, systematic reviews, literature reviews, and articles involving children, newly diagnosed patients without primary intervention, or those not completing primary therapy.

Data Extraction

Data extraction was conducted to ensure accuracy and relevance. The first author (AR) conducted screened articles, excluding those clearly outside the inclusion criteria. Articles of uncertain relevance underwent full-text review. Figure 1 (PRISMA flow chart) illustrates the process. An electronic search identified 668 articles, with two excluded before screening. Title and abstract review excluded 449, leaving 217 articles for full-text assessment based on publication year, type, open-access status, and English language.

Nine articles met the final inclusion criteria; 208 were excluded for reasons such as not involving CRC patients, being protocol/development studies, lacking clinical trials/interventions, not following Population, Intervention, Comparison, and Outcome (PICO), not reporting intervention/control group results, or being reviews, conference papers, posters, abstracts, or lacking full texts. Of these, eight did not involve CRC patients, and five did not follow PICO. Ultimately, nine articles were included and are summarised in the

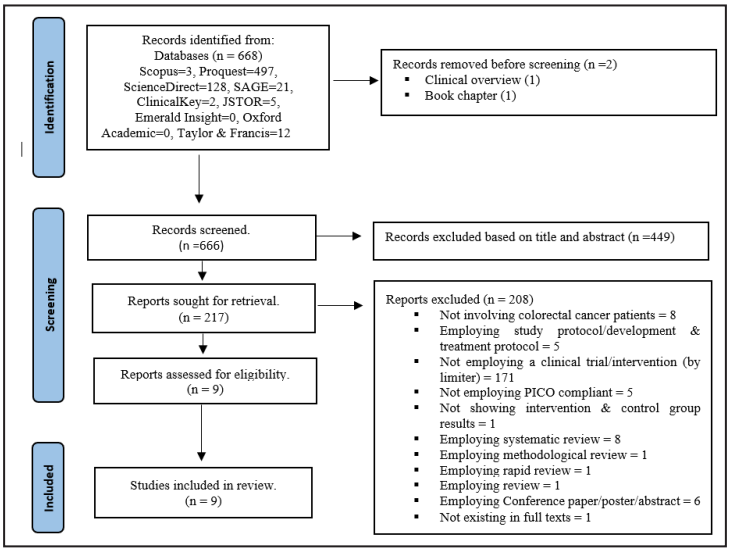

Figure 1: PRISMA Flow Chart

Quality Appraisal

Risk of bias was assessed by using JBI's (Joanna Briggs Institute) critical appraisal tools with 13 criteria rated as "yes," "no," "unclear" (UC), or "not mentioned" (NA).Table 1 summarizes the adherence to criteria across various studies. Zhang *et al*. (2014) met 12 out of 13 criteria, while four studies (Mayer *et al*., 2018; Willems *et al*., 2017; Giesler *et al*., 2017; Raphaelis *et al*., 2020) met 11 criteria. Two studies (Knoerl *et al*., 2019; Takano *et al*., 2021; Reiter *et al*., 2021) met 9 criteria, and Yaacob *et al*. (2020) met 8 criteria, primarily due to missing details on blinding and randomization. Overall, the studies exhibited a low to moderate risk of bias, indicating a need for more consistent and transparent reporting practices.

Table 1: Risk of Bias Summary

Assessed Items	Zhang *et al.* (2014)	Mayer *et al.* (2018)	Knoerl *et al.* (2019)	Takano *et al.* (2021)	Willems *et al.* (2017)	Giesler *et al.* (2017)	Raphaelis *et al.* (2020)	Reiter *et al.* (2021)	Yaacob *et al.* (2020)
Randomisation for sample selection was done correctly.	Yes	Yes	UC	Yes	Yes	Yes	Yes	Yes	No
The assignment to the intervention group was hidden.	NA	NA	NA	UC	Yes	Yes	Yes	NA	NA
The intervention group had similar characteristics to the control group.	Yes	Yes	Yes	UC	Yes	Yes	Yes	Yes	Yes
Respondents were blinded to a group assignment.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
A person delivering the intervention was blinded to group assignment.	Yes	Yes	NA	NA	NA	NA	NA	NA	NA
Outcome assessors were blinded to a group assignment.	Yes	UC	NA	NA	NA	NA	NA	NA	NA
Intervention and control groups received the same treatment (other than the intervention).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Follow-up is complete.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Participants were analysed in the group to which they were randomized.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Outcomes of the intervention group were measured using the same method as that for outcomes of the intervention group.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Outcomes were measured using a reliable method.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
The statistical analysis used was appropriate.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
The trial design was appropriate for the topic, and there were differences between methods and analysis from standard RCTs.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Total number of criteria	12/13	11/12	9/13	9/13	11/13	11/13	11/13	10/13	9/13

Note: "yes" (done), "no" (not done), "unclear" (UC; not clearly described), and "not mentioned" (NA).

Ethical Consideration

The researchers obtained ethical clearance from the Institutional Review Board at Muhammadiyah Institute of Technology and Health, Indonesia with reference number 13/II.I.AU/KET.ETIK/II/2025, on13th February 2025.

RESULTS

The systematic review identified nine RCT articles that provide valuable insights into self-management interventions for CRC patients (table 2). Publication years ranged from 2014 to 2021, with studies conducted in Asia (3), America (2), and Europe (4). Sample sizes varied from 75 to 462, across cancer centres, clinics, and hospitals. Two studies only specified the country (Mayer *et al.*, 2018; Giesler *et al*., 2017), highlighting the global relevance of these interventions.

Table 2: Overview of Article

No.	Researchers, Years, Respondents & Country	Duration, Time of Measurement, & Interventions Performed	Results & Limitations
1	Zhang *et al*. (2014) N=121 (CG =53, IG=68) China	Six months Baseline, month three, month six IG: received standard care plus a six -month psycho -educational self-efficacy programme, including: One-on-one education from an oncology nurse (one hour) before discharge, post-surgery, and at chemotherapy initiation. A pocketbook covering chemotherapy effects, exercise, nutrition, self-efficacy improvement, and common CRC issues. 30 minutes a udio relaxation techniques (breathing and muscle relaxation) to reduce stress and chemotherapy effects, used 12-24 hours before chemotherapy or as needed. Health-coaching phone follow-ups by oncology nurses, 4 times monthly (20-40 minutes each), tailored to individual needs. CG: received standard care and routine nurse instruction (about 30 minutes) before treatment on chemotherapy and its side effects. Additional information was available from doctor or nurse as needed or during follow-up visits.	**Results** Repeated measures MANOVA showed the IG had significantly greater improvements in self-efficacy (F=7.26, p=0.003) and reduc tions in severity (F=5.30, p=0.01), symptom distress (F=4.06, p=0.025), anxiety (F=6.04, p=0.006), and depression (F=6.96, p=0.003) at the 3 and 6 months compared CG. No significant differences were found in perceived QoL. **Limitations** Conducted in only 2 hospitals and 1 cancer centre in Southern China, limiting generalizability; studies in others Asian region are needed. The 6-month follow-up is short for cancer, restricting assessment of long-term effects.
2	Mayer *et al*. (2018) N=284 (CG=140, IG=144) USA	Six months Baseline, month three, month six, month nine IG: Both groups received identical treatment, but the IG used Survivor CHESS smartphone app for information, support, and health promotion, requiring 150 hours of access per week. After 6 months, a licensed trainer coached participant on physical activity through conversation, group or individual sessions, and private messages to encourage engagement. CG: Patients received: The National Cancer Institute's Facing Forward: Life after Cancer Treatment booklet The cancer survival toolbox from the National Coalition for Cancer Survivorships. A pedometer to track steps.	**Limitations** The study depended on rapid technological advances and growing technology adoption. Possible bias towards respondents comfortable with technology. Sample was not representative: 89% Caucasians, 46% highly educated , and 97% insur ed, unlike the general U.S. population. Reliable service delivery was identified across diverse geographic areas.
3	Knoerl *et al*. (2019) N=370 (CG=188, IG=182) USA	Nine weeks Baseline, third, sixth, and ninth week IG: was given the Electronic Symptom Assessment and Self -Care (ESRA-C), which includes tools for tracking, education, communication coaching, symptom control, and self-reporting. CG: Standard tools (electronic symptom assessment, participant symptom reports).	**Results** Most responders (73.8%) followed the advice of their clinicians. Only a small percentage of respondents (49.2%) employed additional self -management techniques for SQIs. Limitations Not mentioned
4	Takano *et al.* (2021) Jepang N=200 (CG=100, IG=100) Japan .	24 weeks (six months) Baseline, week 12, week 24 IG: Patients received standard chemotherapy, supportive care, and a Japanese self-help workbook with: Information on the disease, care, coping, medical information, communication with healthcare providers, decision -making, and goal setting. A questionnaire to identify goals, priorities, and questions for medical staff. Periodic surveys and review of recommendations at week 12 and 24 to assess engagement and behaviours. CG: Patients received standard chemotherapy and supportive care only, without a workbook.	**Results** GQOL scores at baseline, week 12, and week 24 were as follows: CG: 63.4 (22.0), 60.3 (23.4), and 60.8 (21.5) IG: 65.9 (19.8), 63.5 (20.5), and 63.1 (19.6) No significant interaction between intervention and time points (P=0.964), nor on functional scales. **Limitations** The workbook was used without direct expert support. Few subgroups and unbalanced baseline

			characteristics (age, metastasis, prior chemotherapy). Single-study with a uniform population (breast, colorectal, stomach, and lung cancers with or without metastases).
5	Willems *et al*. (2017) N=462 (CG=231, IG=231) Netherlands	12 months baseline in month 3, month 6, and month 12 IG: For 6 months, patients access ed the eHealth KNW platform anytime, choosing from 8 video modules on topics such as work, fatigue, anxiety, depression, relationships, social life, physical activity, smoking cessation, and nutrition. Modules, based on Cognitive Behavioural Therapy (CBT) and Problem-Solving Therapy (PST), could be completed in any order. PST: 2 sessions with 4 components: identif ication, goal setting, psychoeducation, action plans, and a 30-days follow-up for goal review. CBT: Included psychoeducation, relaxation, and assignments like behavioural tracking, recognizing dysfunctional thoughts, planning enjoyable activities, and setting new goals. CG: received usual care.	**Results** No differences were observed in emotional / social functioning, depression, or exhaustion between IG and CG at 12 months. Moderator analyses showed that at 6 months, the intervention reduced depression in chemotherapy patients (d=0.36), fatigue in those ≤56 years (d=0.44), and improved social functioning in men (d=0.34). At 12 months, social function ing was higher in those with secondary education (d=0.19) and lower in those with less education (d=0.22). **Limitations** Drop-out rates, especially in IG, may have influenced results, though they were low at 6 and 12 months (11.5%, 17.5%). The sample included many women with breast cancer, who generally had high QoL and low depression.
6	Giesler *et al*. (2017) N=212 (CG=109, IG=103) Germany	6 weeks Baseline, week 2, week 6 IG: had access to the website for two consecutive weeks. CG: did not receive treatment until after six weeks.	**Results** Participants averaged 54 years old (SD 11.1), 58.8% were female, and 73.6% had prior exposure to others' patient experiences online, making the CRC website module ineffective. No intervention effect was observed at 2- or 6 -weeks post-baseline. **Limitations** Respondents were younger (mean=54.1) than the typical German CRC patient (mean=71). Smaller sample size reduced statistical power; extending recruitment was not possible due to time and website launch constraints.
7	Raphaelis *et al*. (2020) N = 153 (CG=92, IG= 61) Austria	24 days Baseline, week 2, week 4, and week 8 after hospital discharge using a mailed or online questionnaire. IG: Nurses with at least 2 years of cancer care experience delivered structured pain self -management (Antipain) after completing 19 training sessions (average duration: 1 hour 36 minutes). CG: received standard care.	**Results** Session averaged 33 minutes in person (usually 2 meetings) and 17 minutes by phone.Only 46% the 9 wards implemented the intervention, with adjustments for power outages. Sub-analysis showed a significant pain reduction (p=0.009) in these wards, though no overall effect was found. Secondary outcomes showed improvements in in-hospital pain treatment (p=0.018), satisfaction with pain self - management information (p=0.002), and self -efficacy (p=0.033). **Limitations** Recruitment was slower and varied across wards and hospitals.
8	Reiter *et al*. (2021) N = 75 (CG=75, IG=189) Germany	The study's timeline and measurement intervals were unspecified, but as a quasi-experimental pilot, the duration was likely short, focusing on feasibility and impact. IG: received structured oncology nurse and nutritional counselling (inpatient and outpatient). CG: received standard care.	**Results** The intervention group benefited from inpatient nurse counselling for discharge management. No differences were noted in general or gastrointestinal side effects, except for xerostomia and dysphagia. However, 90% of those receiving both inpatient and outpatient counselling managed side effects better. Structured nutritional counse lling increased receipt of nutritional information (p=0.001), improved identification of food intolerances (p=0.023), and greater adherence to dietary advice (p=0.003). Most in this group had improved gastrointestinal side effects, except for 4 cases of weight loss. **Limitations** Small sample sizes, short follow-up periods, and potential bias in patient-reported outcomes. Further research is needed to develop comprehensive, sustainable support systems for cancer patients.

9	Yaacob *et al*. (2020) N=100 (CG=50, IG=50). Malaysia	2 weeks Baseline, week 2 IG: used the ColorApp for two weeks CG: did not have access to the app.	**Results** The IG had a greater increase in knowledge scores after using the ColorApp compared to the CG. No significant change in attitudes towards CRC screening in either group. The app improved knowledge, but attitudes change may need longer exposure and additional strategies. **Limitations** Attitude change likely requires longer and more comprehensive interventions.

Note: IG (Intervention Group); CG (Control Group)

Three articles included only CRC patients with specific criteria (diagnosed for at least six months, stages I-III, or diagnosed three years prior (Zhang *et al*., 2014; Mayer *et al.*, 2018; Giesler *et al*., 2017), while the other six included CRC alongside other cancer types. Intervention duration ranged from 24 days to 12 months and reflected differences in patient needs, cancer stage, and targeted outcomes. Shorter interventions (Raphaelis *et al.*, 2020) focused on acute symptom management, while longer ones (Willems *et al*., 2017) aimed at sustained behaviour change and long-term QoL. Methods included psychoeducation, smartphone apps, self-help workbooks, eHealth, pain self-management, oncology and nutritional counselling, and health education apps. Control groups received either the same intervention or standard care post-study. These varied approaches underscore the adaptability and multifaceted nature of self-management strategies.

Most interventions yielded positive outcomes, including improvements in self-efficacy, QoL, distress, anxiety, depression, physical activities, adherence, symptom management, functioning, competence, social support, and pain management. Notably, Zhang *et al.*, (2014) reported significant increases in self-efficacy and reduction in symptom severity and psychological distress. Mayer *et al*., (2018) found improved physical activity at 6 months, though not sustained at 9 months. Knoerl *et al*., (2019) noted high adherence, no significant compliance. Takano *et al*., (2021) showed emotional functioning benefits from self-help workbooks. Willems *et al*., (2017) found subgroup-specific improvements. Raphaelis *et al*. (2020) reported better pain management and self-efficacy. Reiter *et al*., (2021) observed improved management of side effects and nutritional challenges. Yaacob *et al.*, (2020) found increased knowledge but no significant attitude change, suggesting longer exposure may be needed. Overall, these findings support the effectiveness of self-management interventions for CRC patients.

DISCUSSION

The findings from this systematic review highlight the critical role of self-management interventions in CRC care. Programmes like Coping-Together demonstrate benefits for patient-caregiver dyads, showing the value of both lay and clinician guidance (Wiesenfeld *et al*., 2025; Lambert *et al*., 2025). Integrating these interventions into standard care can be achieved with personalised electronic care planning tools, such as the COMPASS-CP for CRC survivors (Sohl *et al*., 2023). Aryani *et al*., (2024b) identify innovative strategies, including psychoeducational programmes, technology-based interventions, and structured counselling that collectively enhance patients' self-management and QoL. Despite the promising outcomes, several challenges remain. A major gap is the limited understanding of barriers and enablers in cancer self-managing, such as lack of awareness limited access, and emotional hurdles (Pallin *et al.*, 2024). Addressing these barriers is crucial for maximising intervention effectiveness.

The review emphasises the need for interventions that address both physical and psychosocial aspects, including soft skills like self-efficacy and acceptance. Higher self-efficacy improves symptom control and reduces anxiety and depression (Zhang *et al*., 2014; Mayer *et al*., 2018). Good self-acceptance aids adaptation, reduces stigma, and enhance social relationships. Current interventions often overlook these aspects, highlighting a gap for more uniform approaches for comparison. Innovative approaches and technologies are essential for comprehensive, patient-centred care. Nurses play a pivotal role in designing, implementing, and evaluating self-management interventions, bridging clinical guidelines and patient needs. By applying evidence-based practices, nurses tailor interventions, improving adherence and QoL (Kitsiou *et al*., 2025).

Lambert *et al*. (2025) emphasise nurses' role in translating evidence-based interventions through a

stepped-care approach, enhancing self-efficacy and empowerment. Ejezie *et al*. (2025) highlight digital health interventions where nurses boost engagement and adherence by providing timely support and education. Nurses integrate self-management interventions to enhance outcomes, as shown by Jarelnape *et al*. (2024), who demonstrate significant improvements due to direct interactions and personalised care. Nurses educate patients, equipping them to manage conditions, adhere to treatments, identify risks, and prevent adverse events. Sassen (2023) underscores nurses' critical role in promoting health. The nurse integration model includes cognitive-behavioural therapy, online learning, and support groups (Aryani *et al*., 2023). Oncology nurses provide essential skills for managing symptoms, psychological adjustment, and relaxation, crucial for cancer recovery and QoL (Wang *et al*., 2023). In summary, nurses are essential in shaping CRC self-management, integrating clinical knowledge with patient-centred care to improve outcomes.

Further research should explore interventions that improve soft skills, such as acceptance and self-efficacy, within self-management programmes. Longitudinal studies are needed to assess the long-term effects of these skills on CRC patients' QoL. However, this systematic review is limited by the small number of articles on CRC interventions, which may restrict generalisability. Additionally, the heterogeneity of interventions and methodologies across studies complicates direct comparisons and synthesis of results. Most studies included homogeneous populations, further limiting the applicability of findings to broader patient's groups. Short follow-up periods in many studies also hinder the assessment of long-term intervention effects and sustainability. Enhancing soft skills, particularly acceptance and self-efficacy, is crucial for improving QoL. Future studies should include more diverse populations, longer follow-up periods and standardised protocols to facilitate effective comparisons and strengthen evidence for CRC self-management strategies.

Limitation

This systematic review is subject to several limitations. Firstly, the number of eligible studies was relatively small, with only nine randomised controlled trials meeting the inclusion criteria. This restricts the generalisability of the findings, especially given the diversity of interventions, sample characteristics, and settings. Secondly, considerable heterogeneity existed among the included studies in terms of intervention duration, delivery methods, outcome measures, and populations involved, making it challenging to perform a meta-analysis or direct comparison of effectiveness. Thirdly, many studies lacked long-term follow-up, limiting the ability to evaluate the sustained impact of self-management interventions on colorectal cancer patients' quality of life and psychological well-being. Additionally, several studies focused on mixed cancer populations rather than colorectal cancer patients exclusively, which may dilute the relevance of the findings to this specific group. Moreover, the risk of bias assessments revealed inconsistencies in reporting randomisation procedures, blinding, and intervention fidelity, suggesting that some findings may be influenced by methodological weaknesses. Lastly, most studies were conducted in high-income countries, with limited representation from low- and middle-income settings, thereby reducing the global applicability of the results.

CONCLUSION

These findings highlight the crucial role of self-management strategies in empowering CRC patients to actively participate in their own care by managing symptoms, treatments, and the physical as well as psychosocial impacts of the disease. These interventions also support patients in navigating relationships with family, community, nursing and healthcare professionals. By fostering self-efficacy and acceptance, self-management programmes can significantly improve QoL. Integrating digital health technologies increases accessibility, engagement, and personalised support, helping to overcome geographical and logistical barriers. Future research should examine the long-term effects of self-management interventions in diverse populations. Tailoring interventions to individual and cultural needs can enhance effectiveness. Standardised protocols will enable better comparisons and strengthen the evidence base. In conclusion, self-management interventions are essential for improving well-being in CRC patients. Integrating innovative approaches, nursing roles and technology will be key to delivering comprehensive, patient-centred care that addresses both medical and psychosocial needs.

Recommendation

Self-management interventions should be integrated into routine colorectal cancer care to enhance patients' self-efficacy, symptom management, and quality of life. Tailored programmes that combine psychoeducational, digital, and nurse-led support can address both physical and psychosocial needs effectively. Future efforts must focus on developing standardised, culturally sensitive interventions with longer follow-up to ensure sustainability and broad applicability. Nurses and healthcare providers play a vital role in delivering personalised, evidence-based self-management support to improve patient outcomes.

Conflict of Interest

Regarding this topic, the writers have no conflicts of interest.

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