Ostomy Care: Case Study Review

Lyric Corbett Smith RN, BSN, WOCN, CFNC

Objectives

- Brief Historical perspective
- Review of procedures for fecal diversions
- Basic pre-and post operative care
- Case Studies of Complications
  - Stomal necrosis
  - Stomal retraction
  - Allergic Dermatitis
  - Candidiasis
  - Irritant Dermatitis
  - Peristomal hernia

Short Historical Perspective

High mortality rates prior to ostomy surgery

1st planned ostomy surgery took place in 1793

1800 Development of Anesthesia

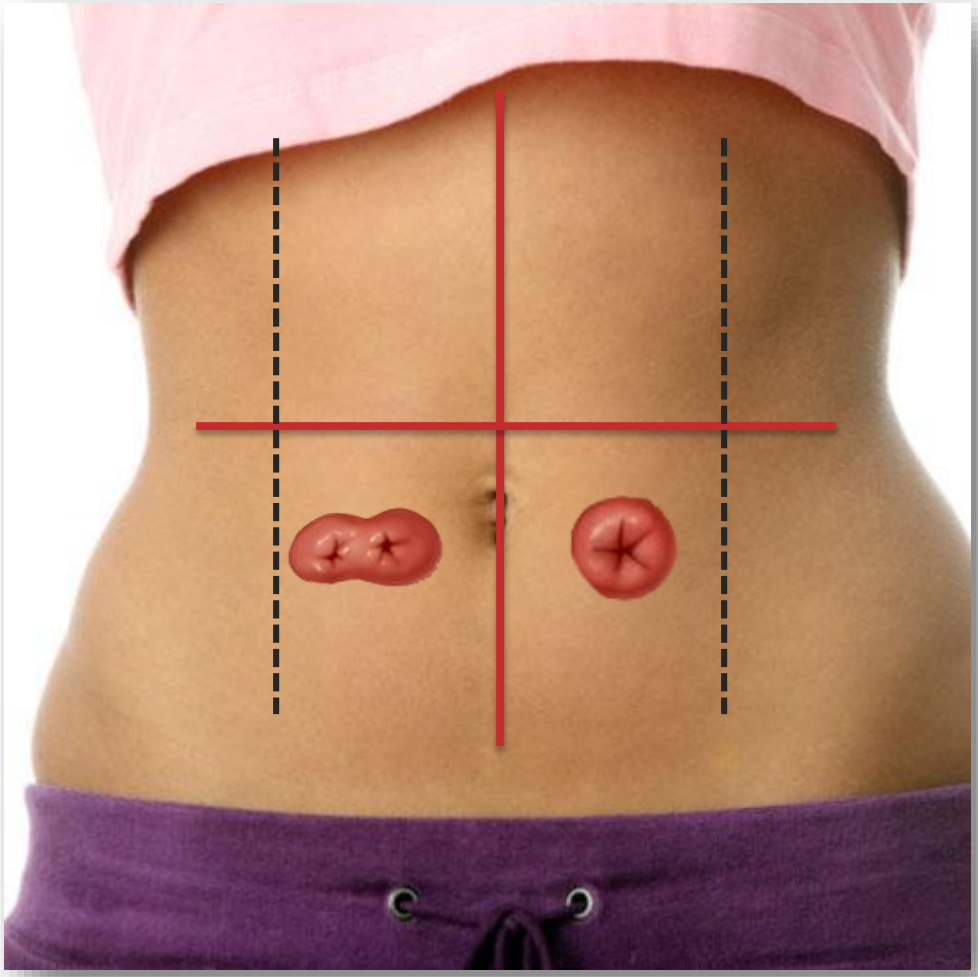
1900 Hartman's Pouch

Self maturation of the stoma

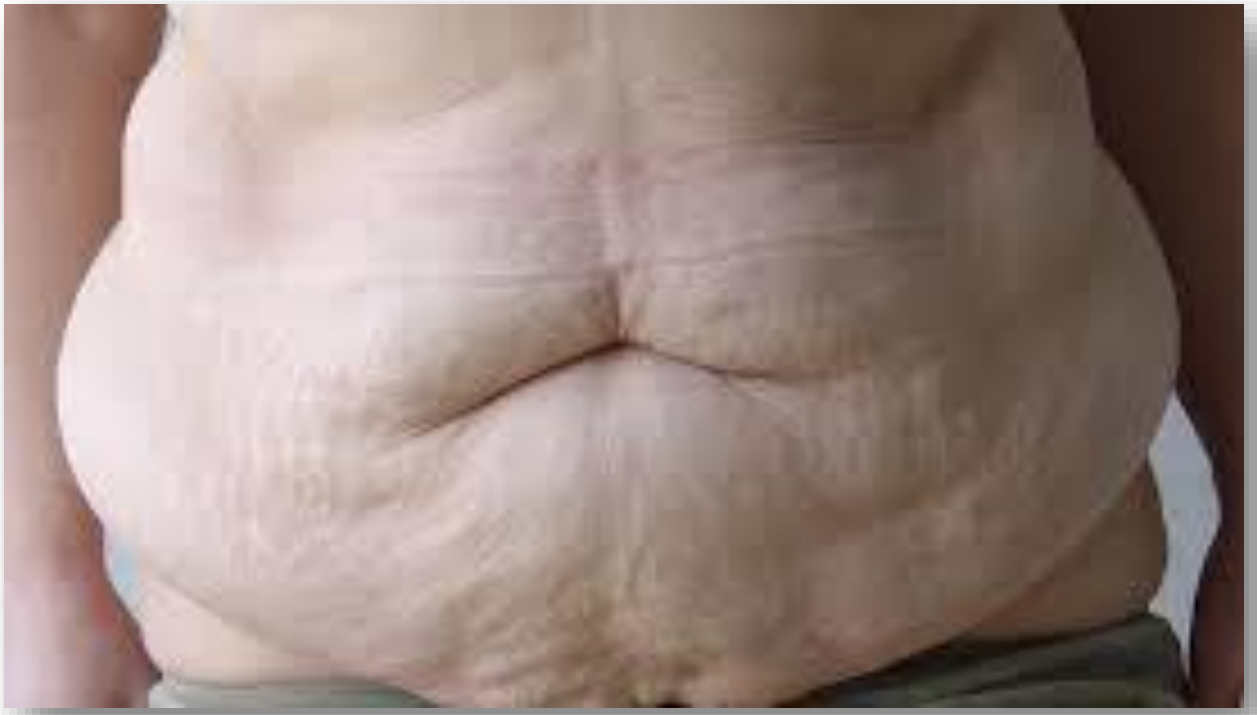
1950 Brooke Procedure

Mid 20th Century ET nurse Role

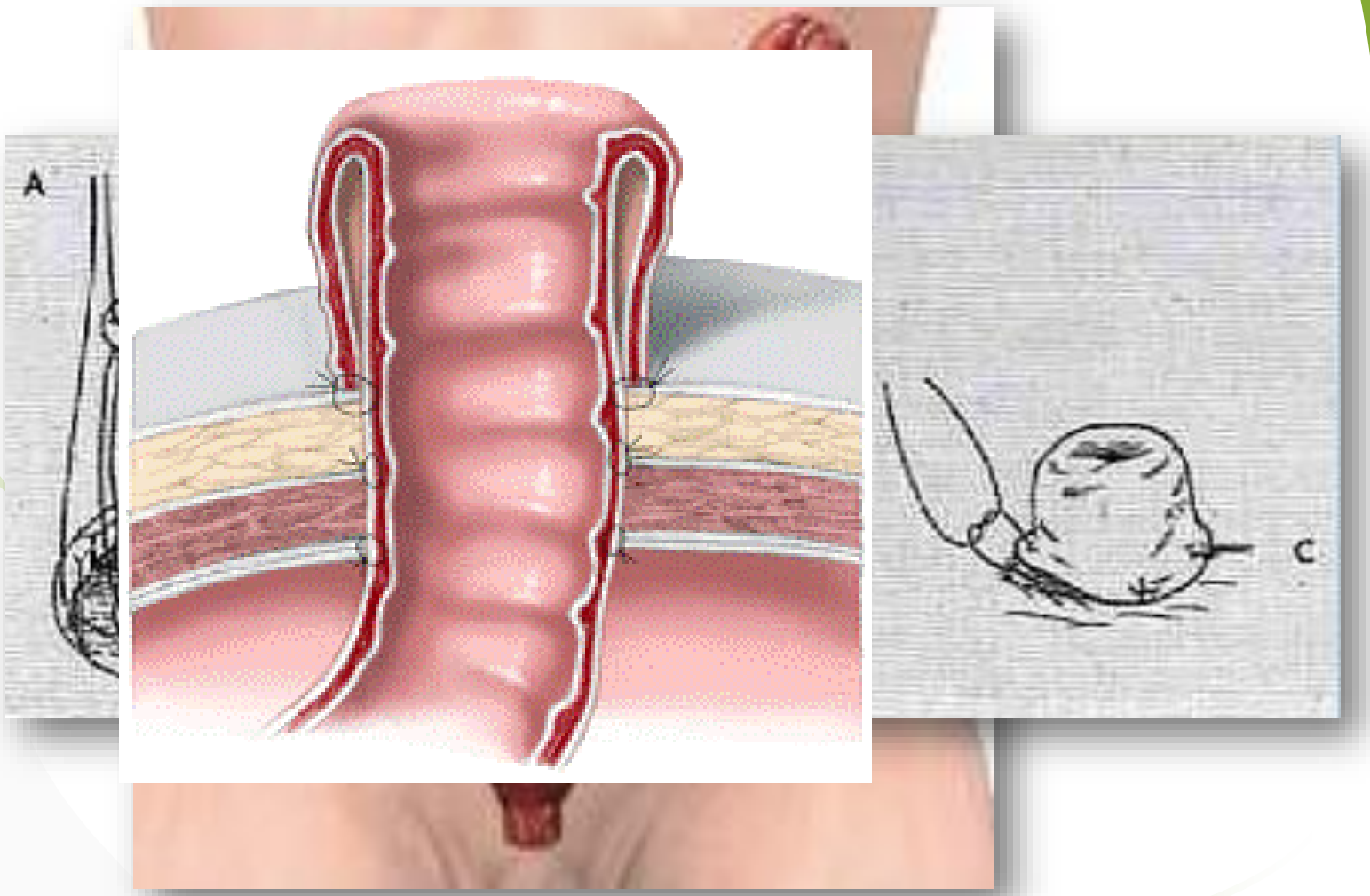
Anatomical Position



Challenging Anatomy

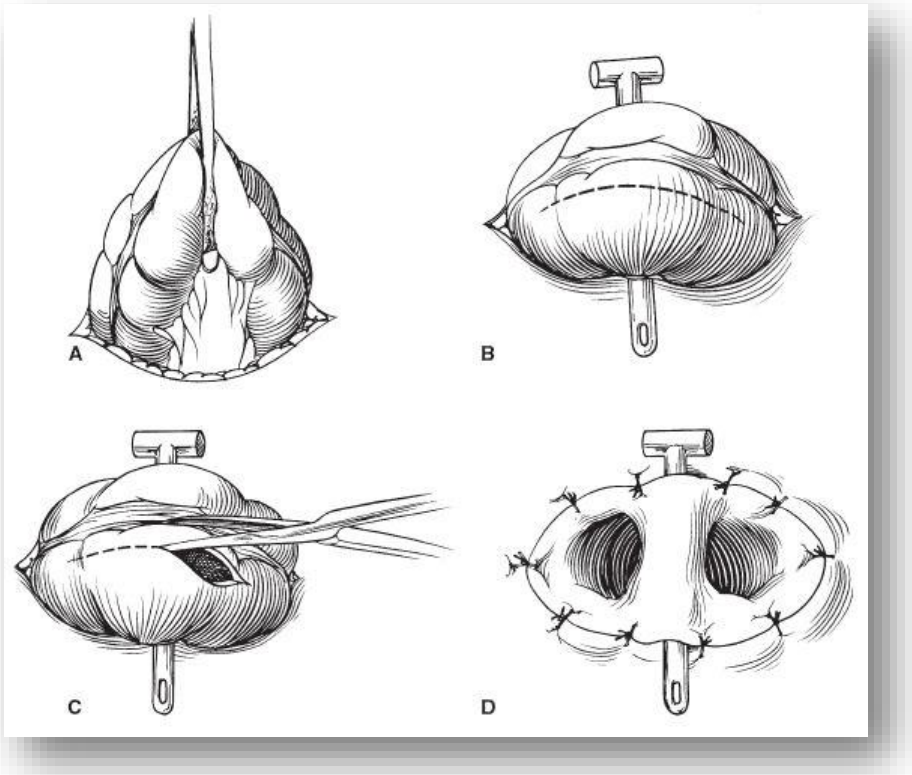


Stoma Construction – End Ostomy



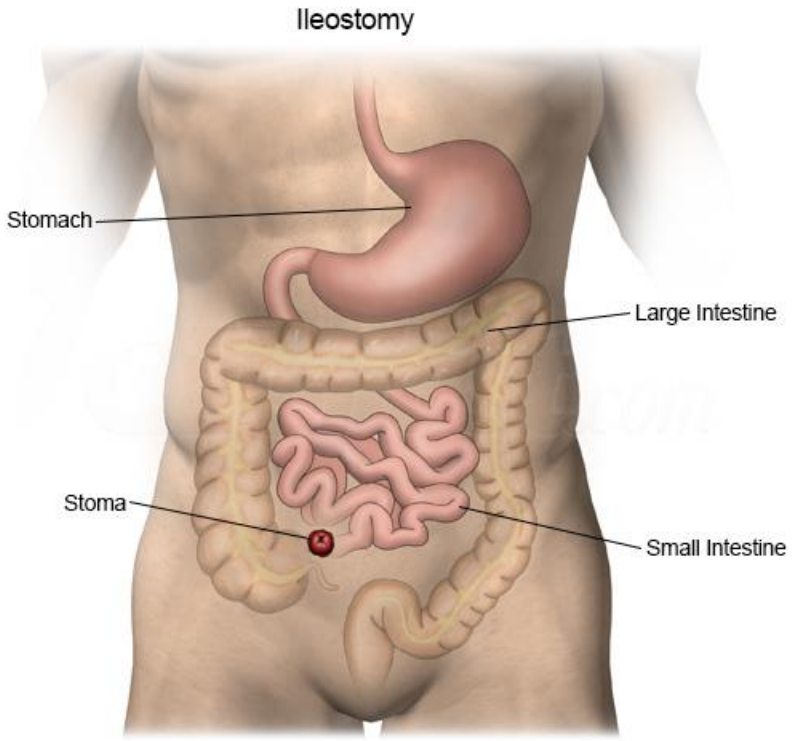
Stoma Construction – Loop Ostomy

- **Loop Ostomy**
  - Proximal/ Distal
  - Bridge Device
  - 2 openings
  - Generally temporary



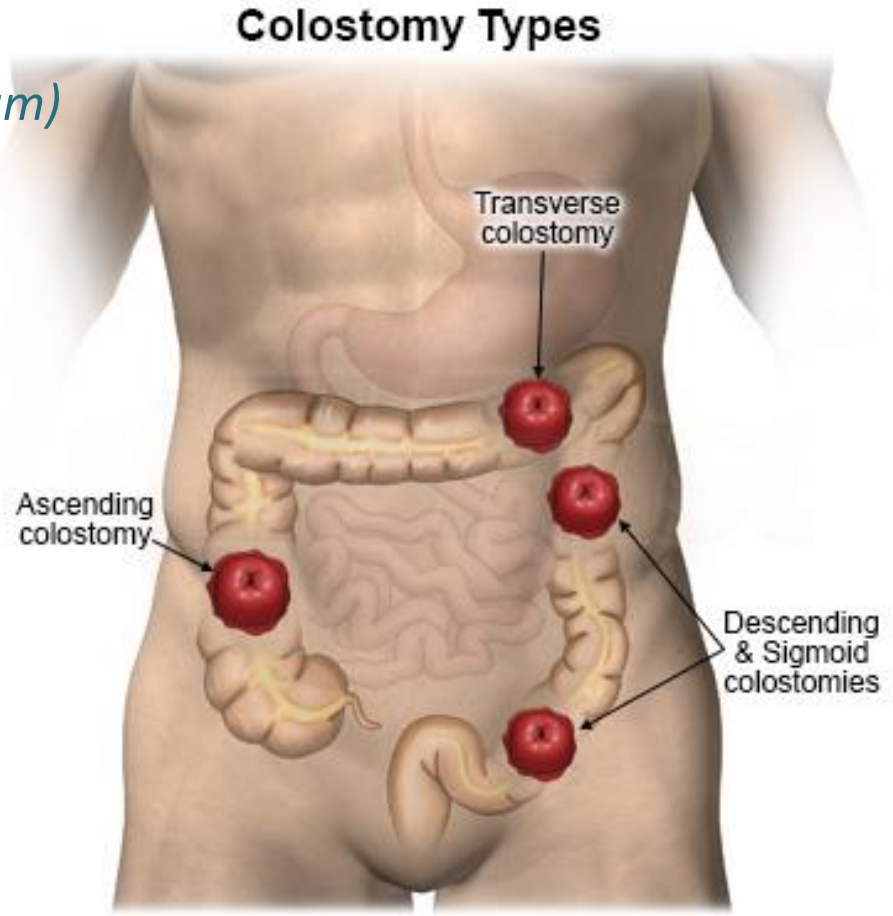
Ileostomy

- **Small Intestine** ***(duodenum, jejunum, ileum)***
  - Digestion
  - Absorption
- **Ileostomy**
  - Soft mushy stool
  - Dehydration
  - B12 absorption
- **Pouch**
  - Worn at <u>all</u> times
  - Constant peristalsis
  - Drainable
- **Why?**
  - Inflammatory bowel
  - Protection of distal anastomosis

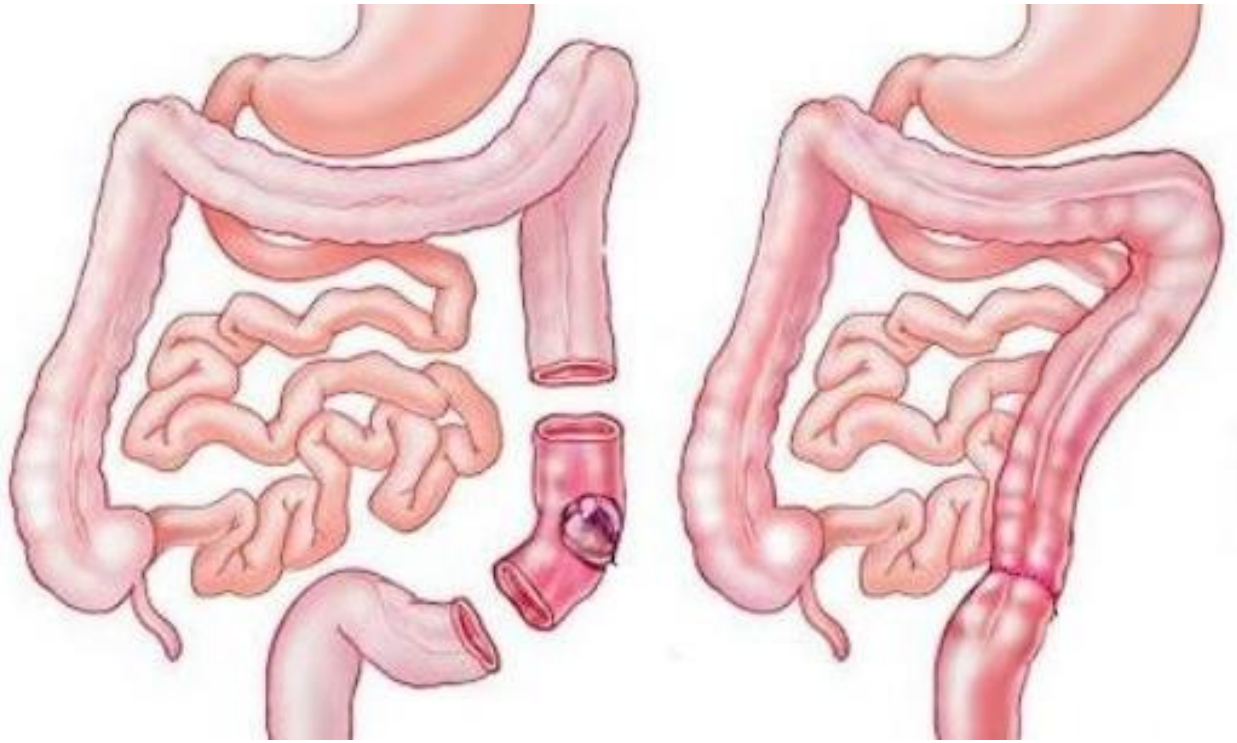


Colostomy

- **Large Intestine** *(cecum, colon, rectum)*
  - Storage and elimination
  - Water absorption
- **Colostomy**
  - Sigmoid Colon
    - Formed stool
    - Mass movements
- **Pouch**
  - Regulate bowel function
- **Why?**
  - Diverticulitis with perforation
  - Rectal Cancer

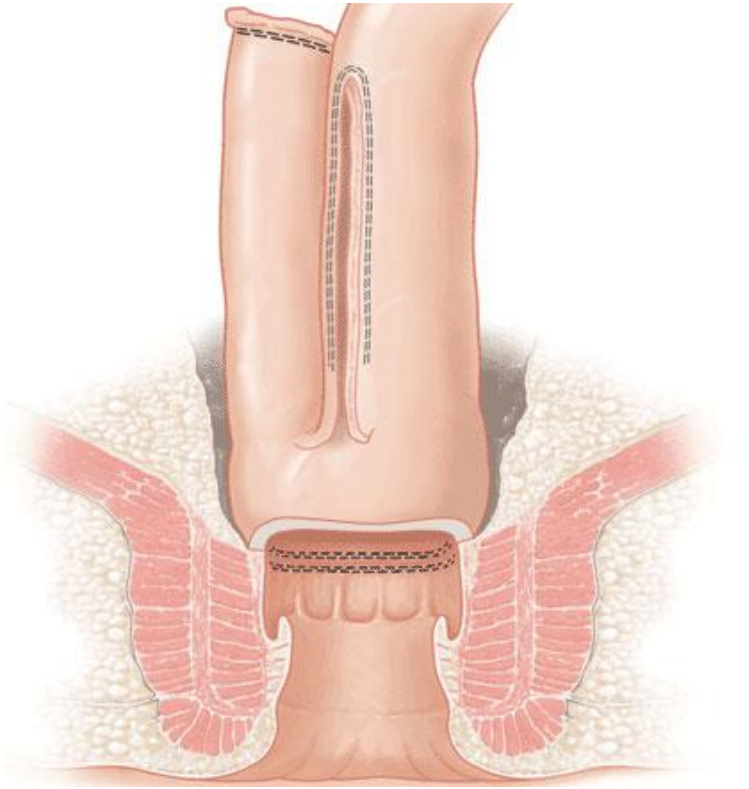


Temporary Ostomy

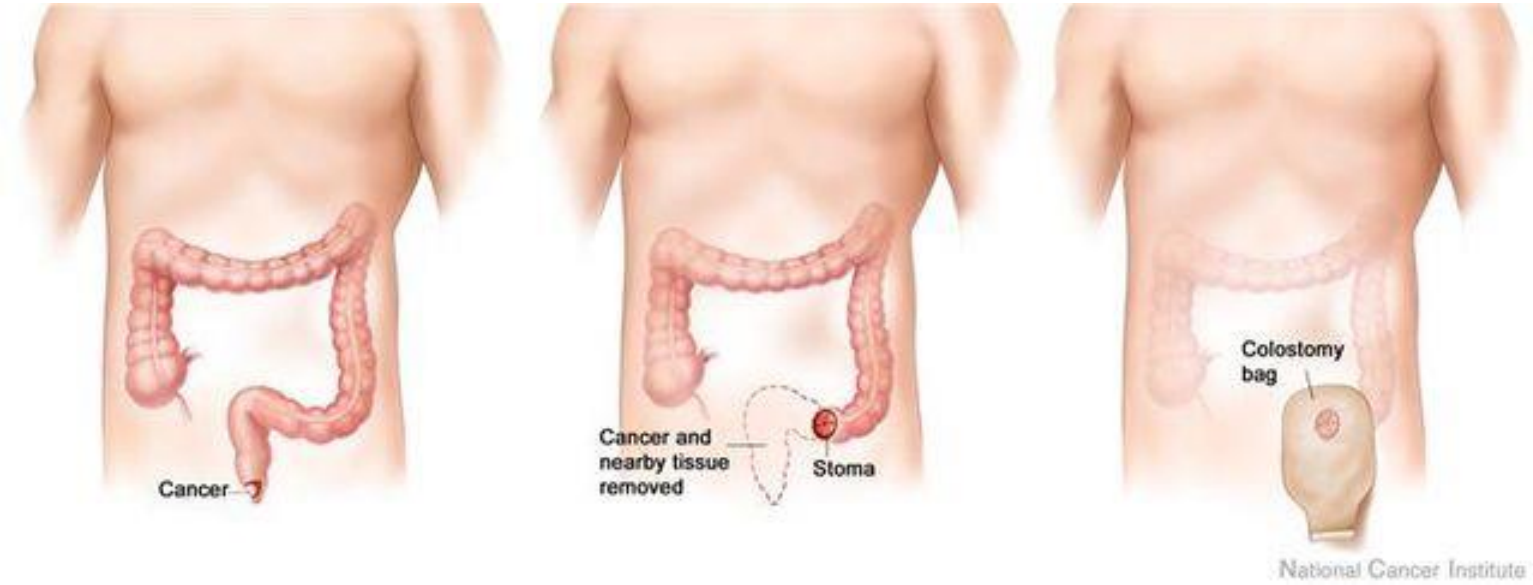


Ileal Anal Anastomosis with J Pouch

- Staged procedure
  - Colectomy/Proctocolectomy
  - Loop ostomy
  - Creation of internal pouch
- Temporary Loop Ileostomy
  - 6-8 weeks
- Last stage provides natural evacuation
  - 6-8 soft stools/day
  - Approx 6 months

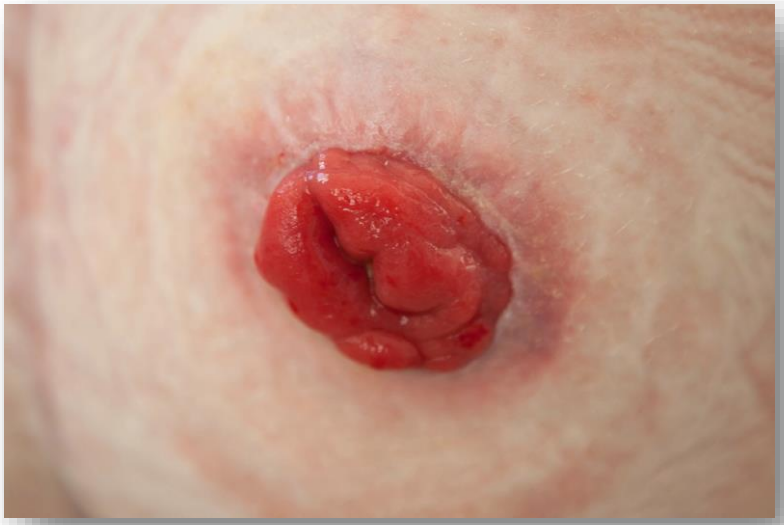


Permanent Ostomy - APR



Peristomal Skin

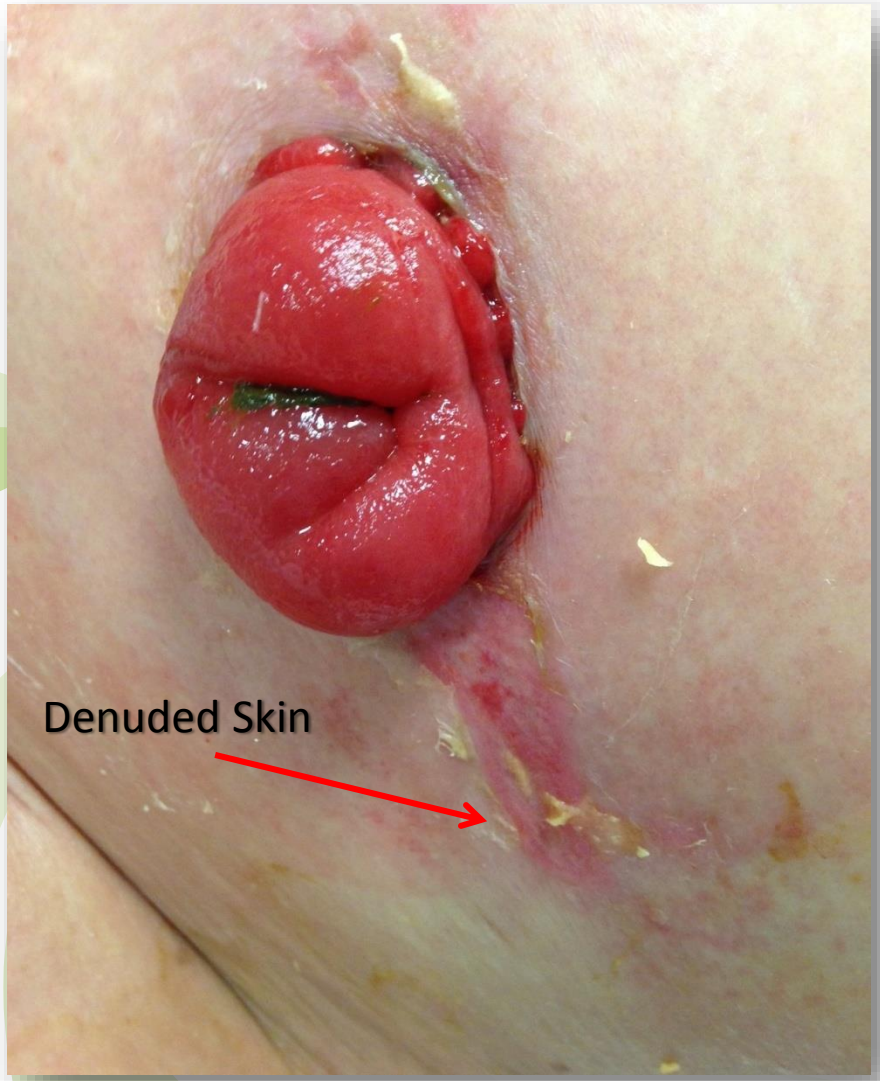
- Healthy, intact with no erythema, rash, or lesions

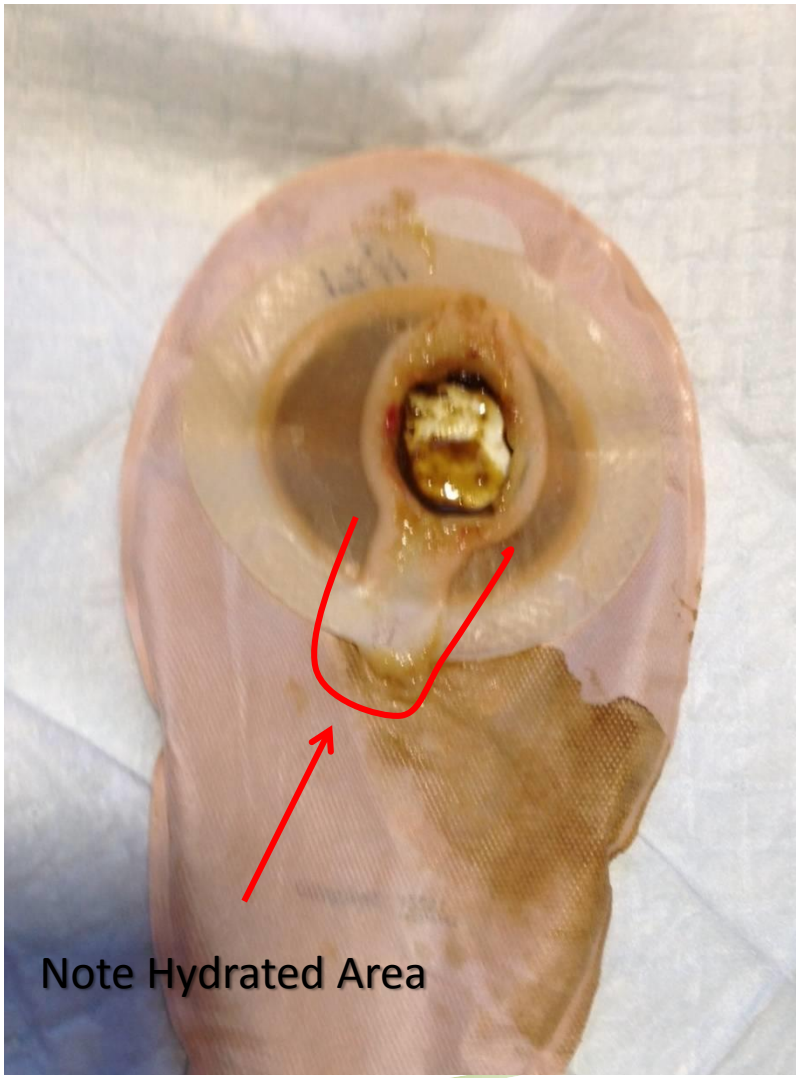


Goal of basic Pouching

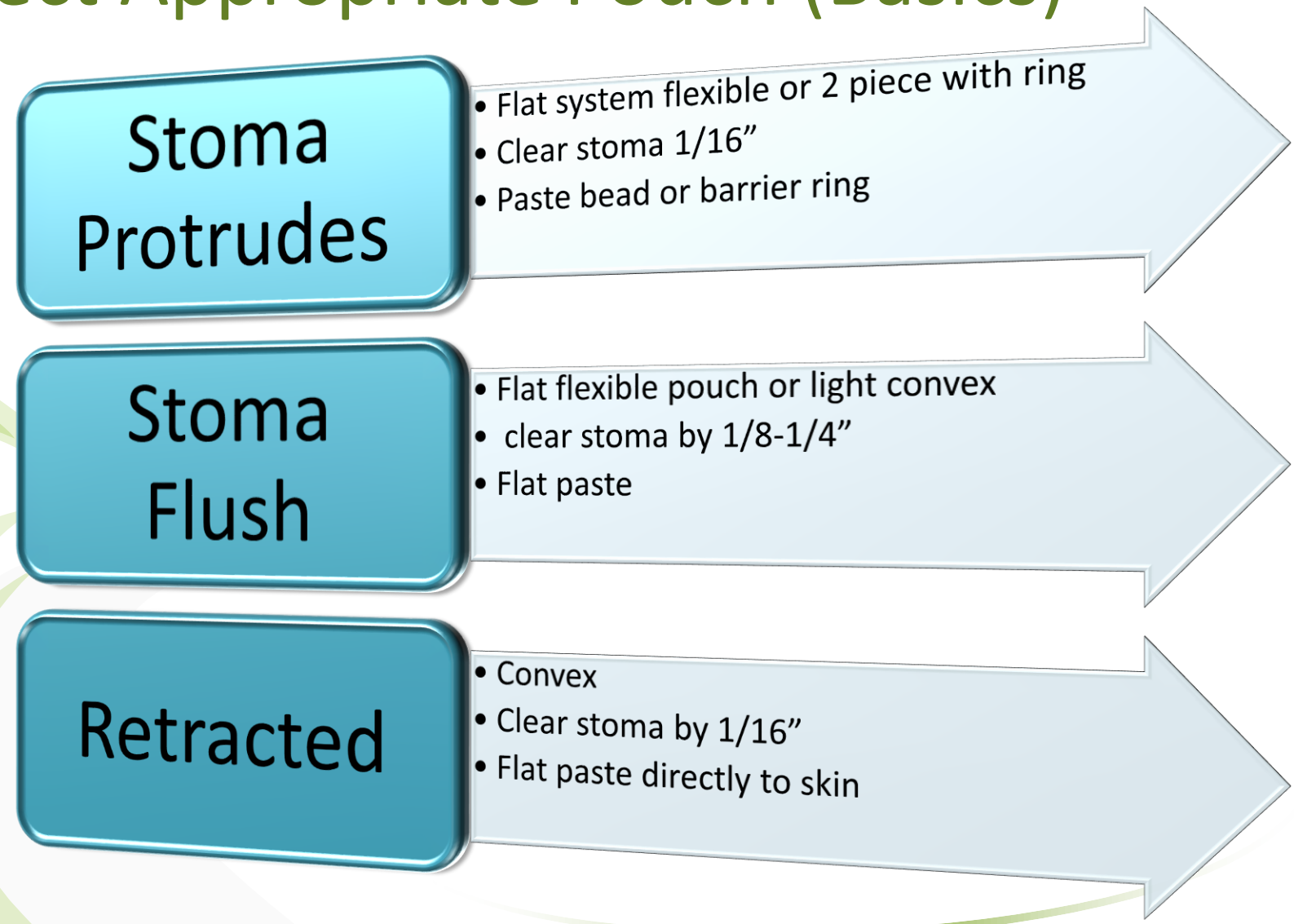
Protect Peristomal skin, clear the mucosa & maintaining a seal for prescribed period of time!

Leakage Assessment and Treatment



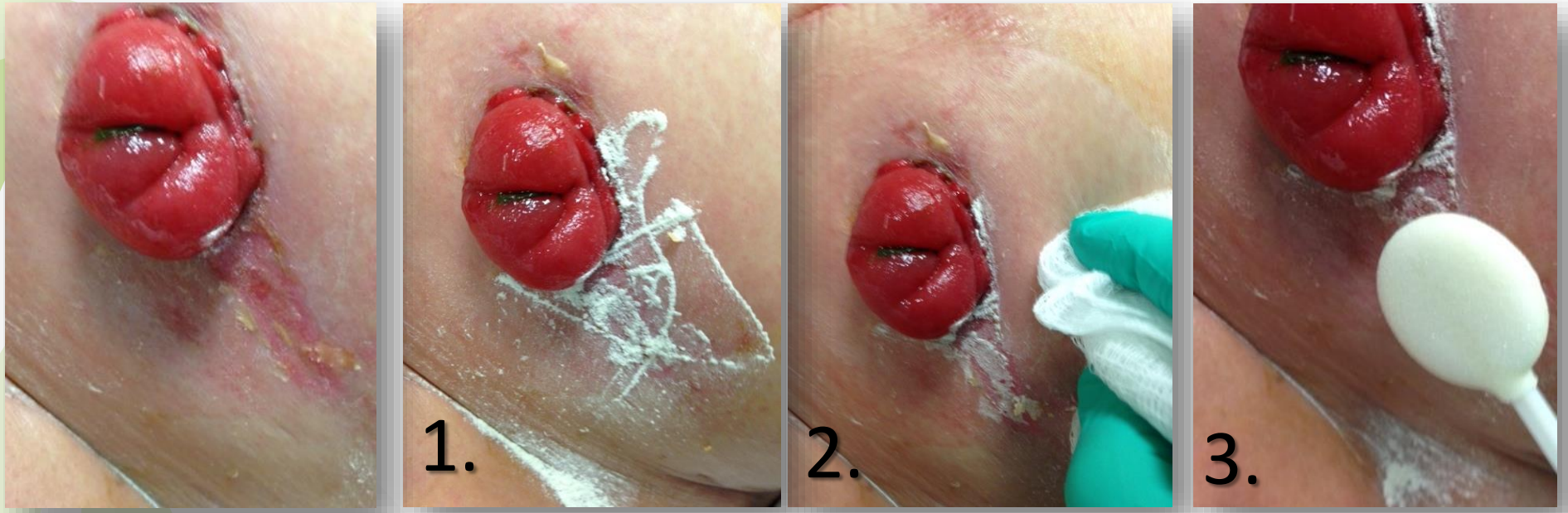


Select Appropriate Pouch (Basics)

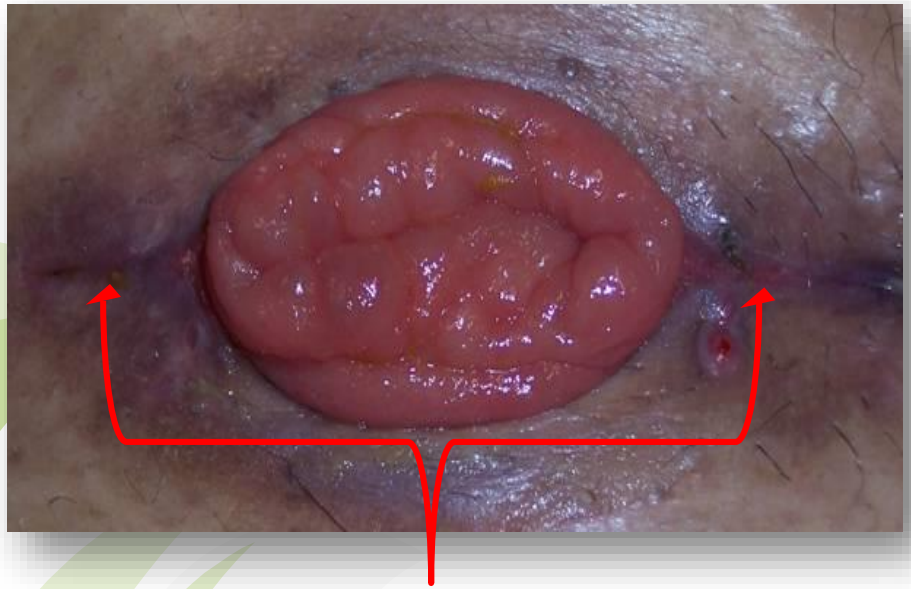


Crusting Peristomal Skin

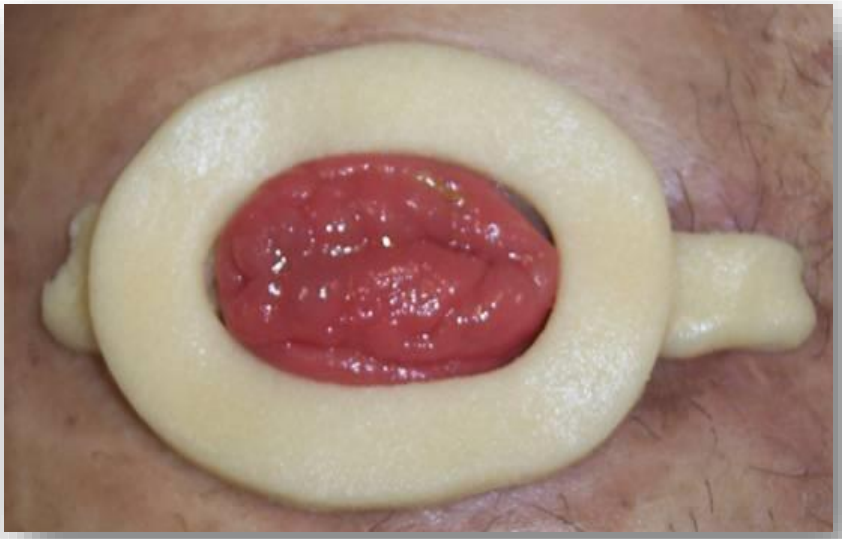
1. Dust Area with Stoma Power
2. Gently brush off excess *(powder will stick to denuded area)*
3. Seal in with a “Sting Free” Barrier



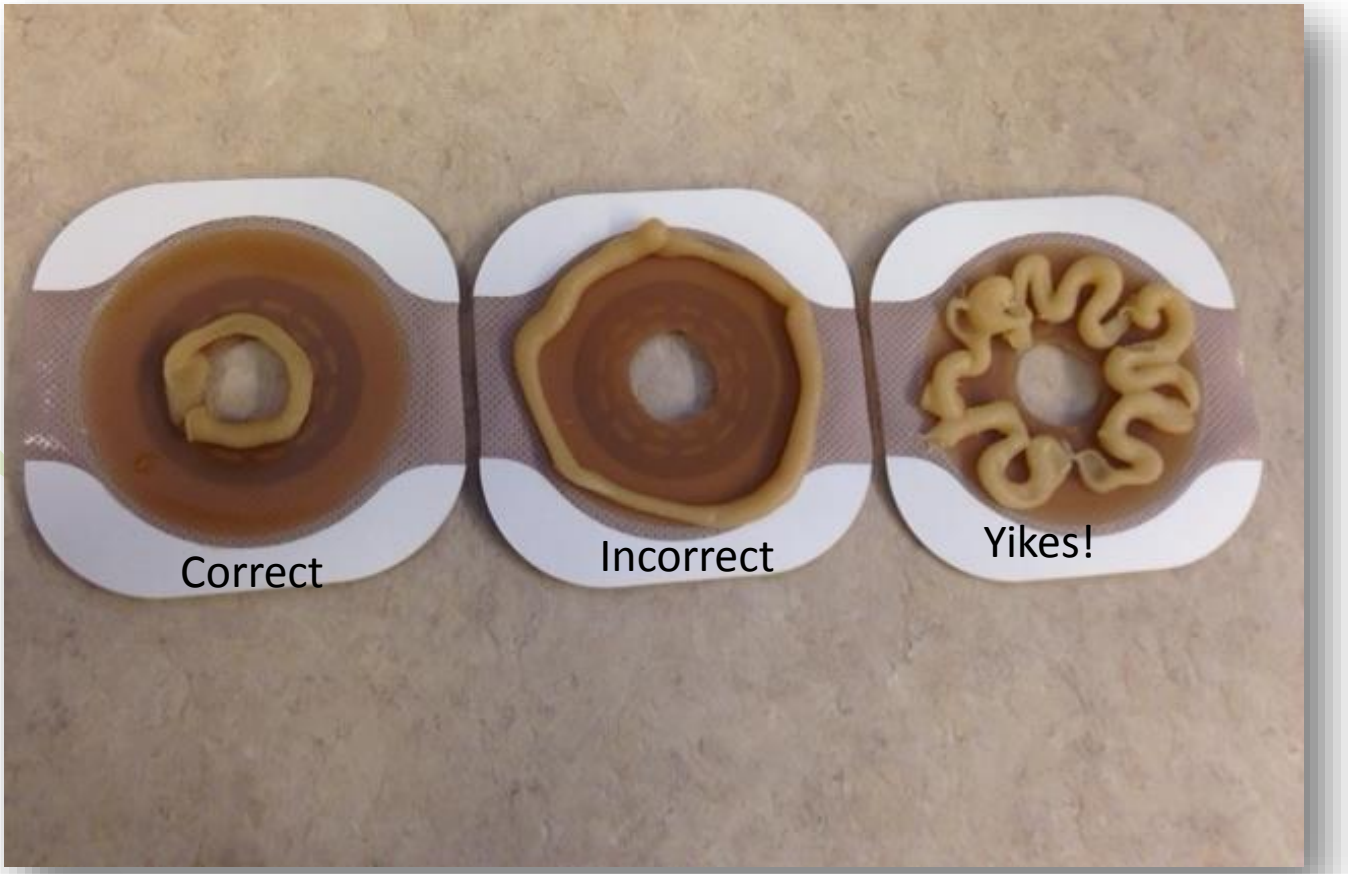
Barriers and Paste.



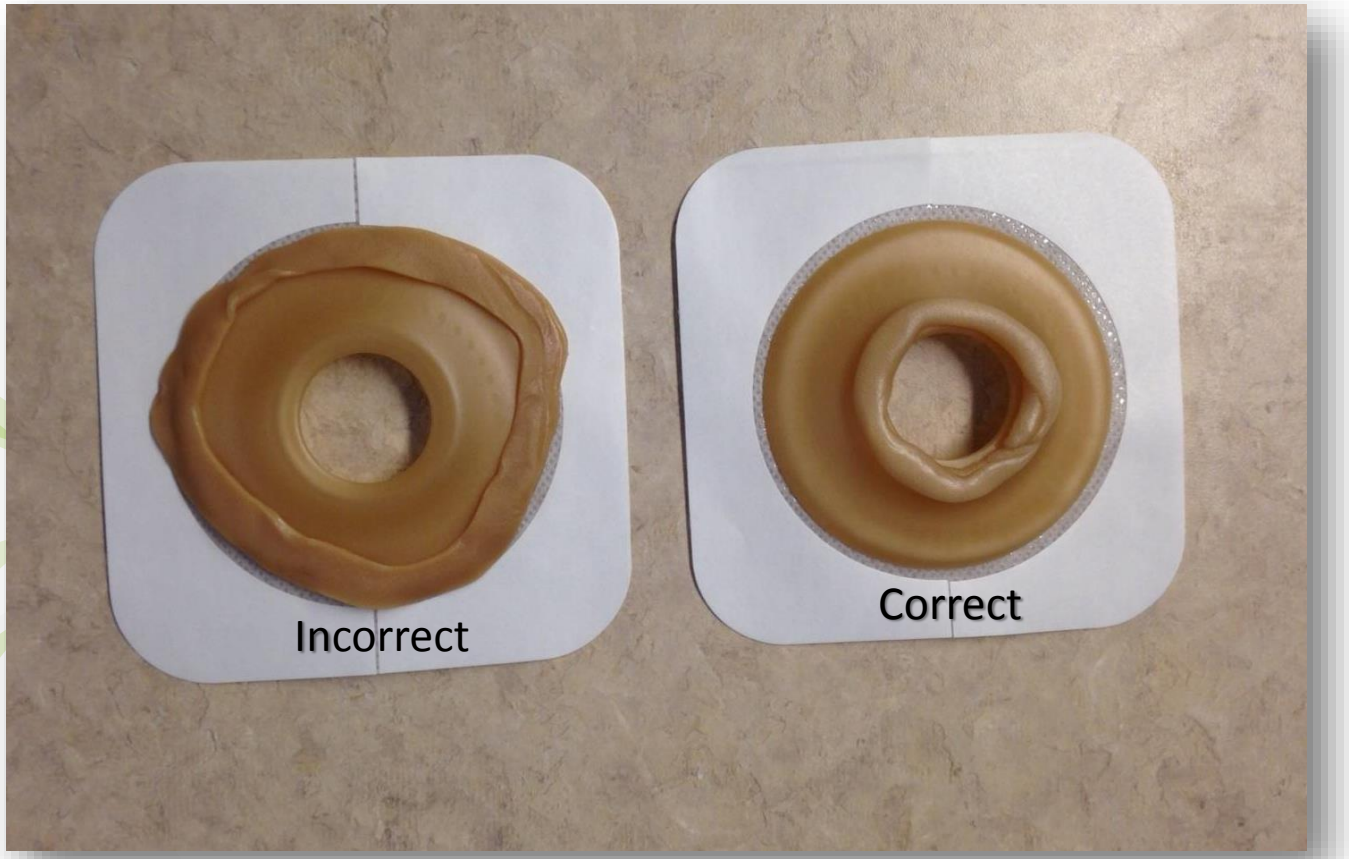
Skin Creases at
3:00 and 9:00



Correct use of paste.

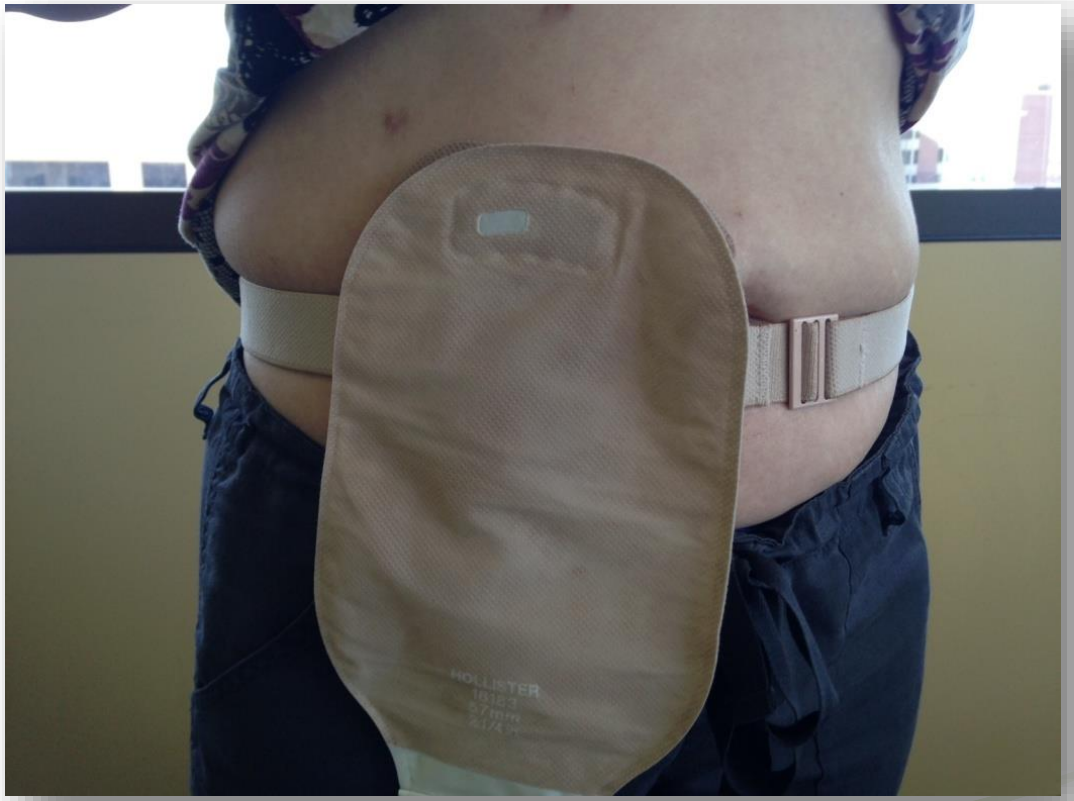


Correct use of Barrier Ring



Belts

- Additional support at 3:00 and 9:00



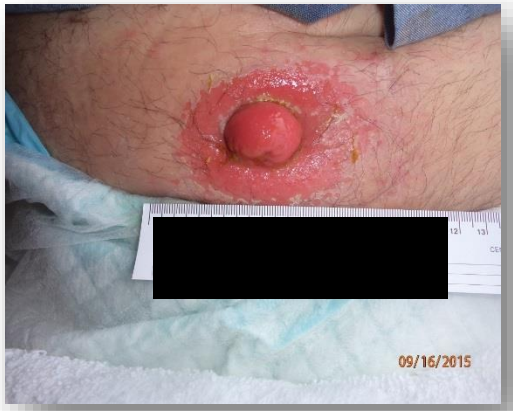
References

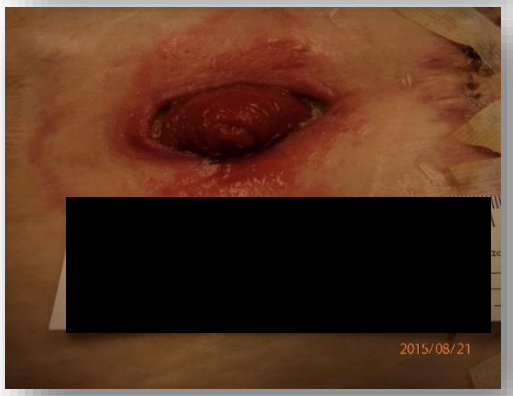
1. Colwell, J., Goldberg, M., Carmel, J., *Fecal and Urinary Diversions, Management and Principals.* Mosby, Inc. 2004
2. Doughty, D. History of Ostomy Surgery. *Journal Wound Ostomy Continence Nursing.* 2008; (35):34-38.
3. University. *Wound Ostomy Continence Nursing Education Program*. 2013. Copyright Emory University.
4. Jordan, R., Burns Ladonna,J., *Understanding Stoma Complications*. Wound Care Advisor, 2013 (2): 20-24
5. Zimnicki, K. Preoperative Stoma Site Marking in the General Surgery Population. *Journal Wound Ostomy Continence Nursing*. 2013; (5): 501-505 Lipincott and Williams.
6. By national cancer institute - http://www.cancer.gov/Templates/db_alpha.aspx?CdrID=377733, Public Domain,https://commons.wikimedia.org/w/index.php?curid=3329072

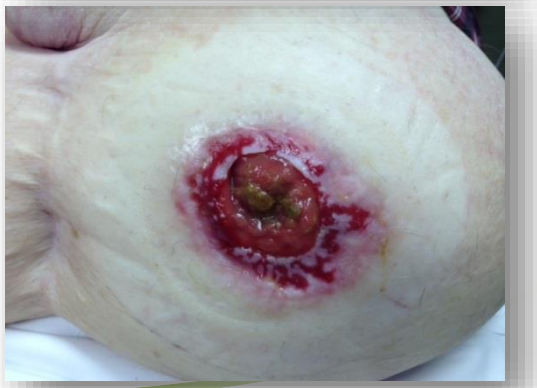
Case Studies

Irritant Contact Dermatitis.

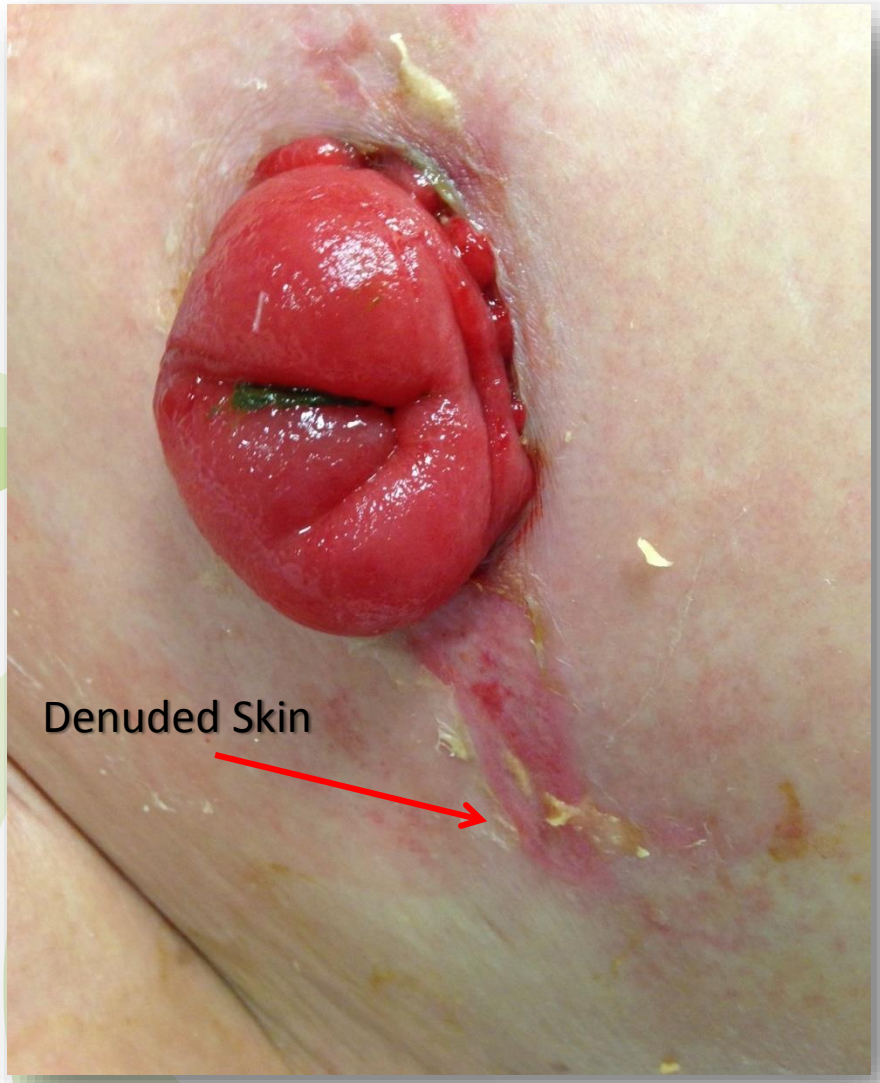
- *Cause/Presentation*:
  - Enzymatic drainage
  - Painful
  - Matches area of leakage
- *Treatment*:
  - Correct cause
  - Assess self care
  - Crusting

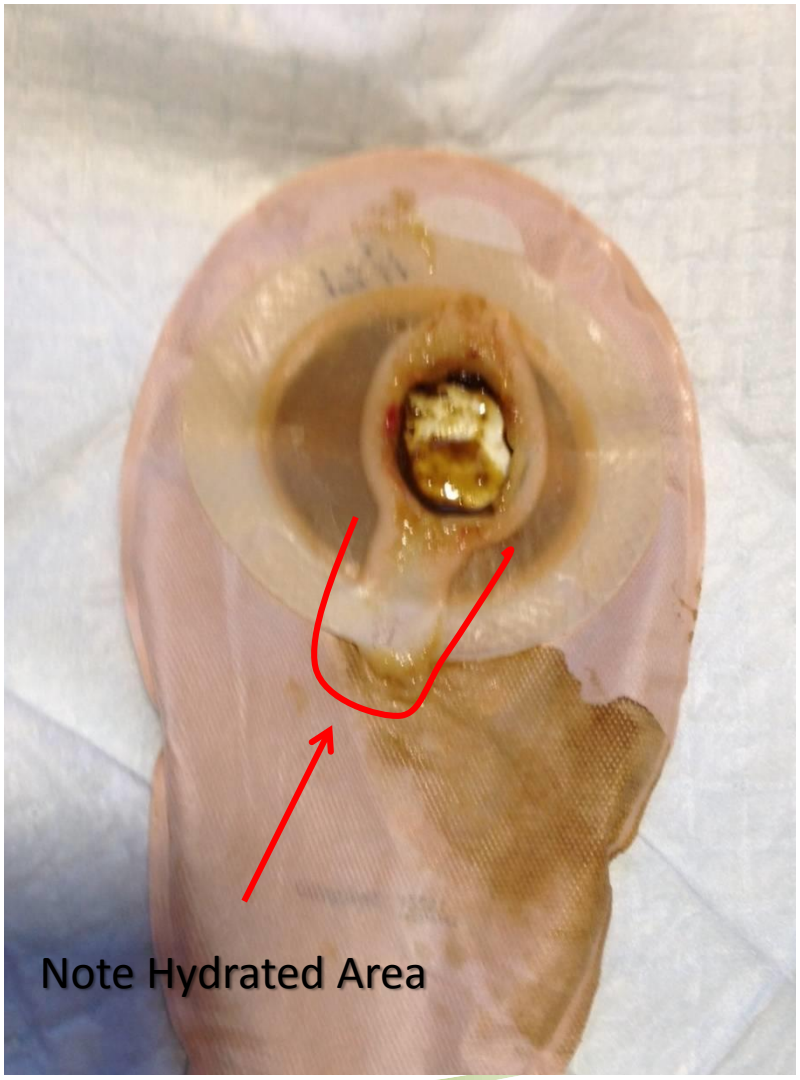






Leakage Assessment and Treatment.





Crusting Peristomal Skin.

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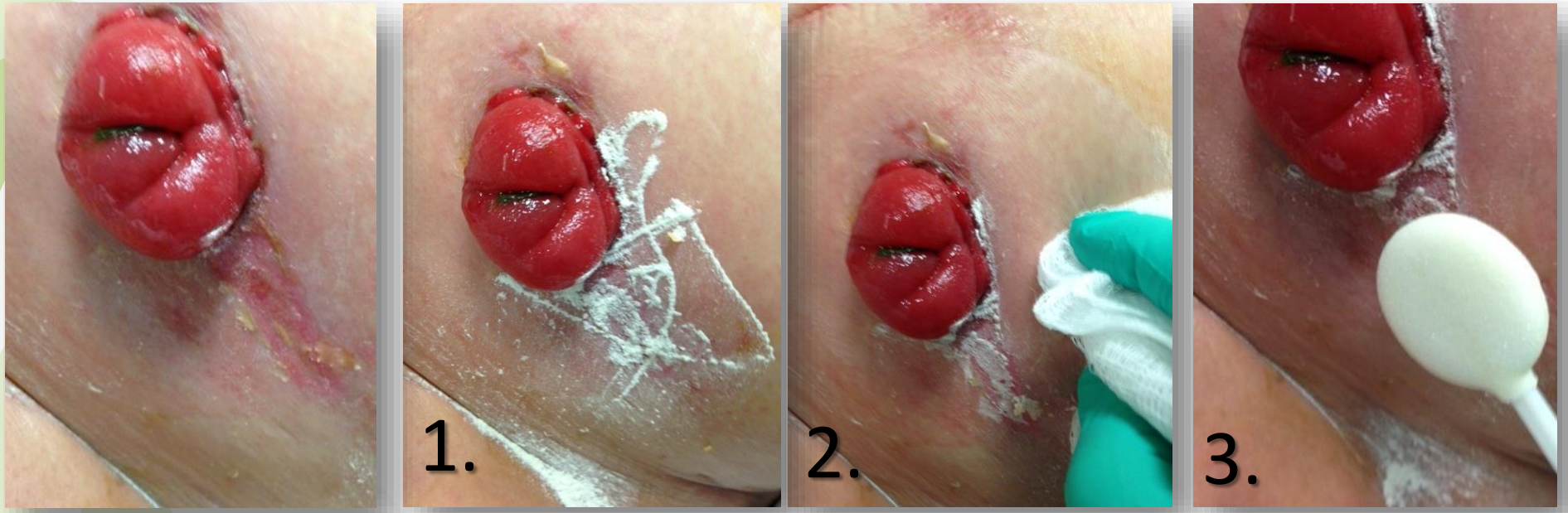
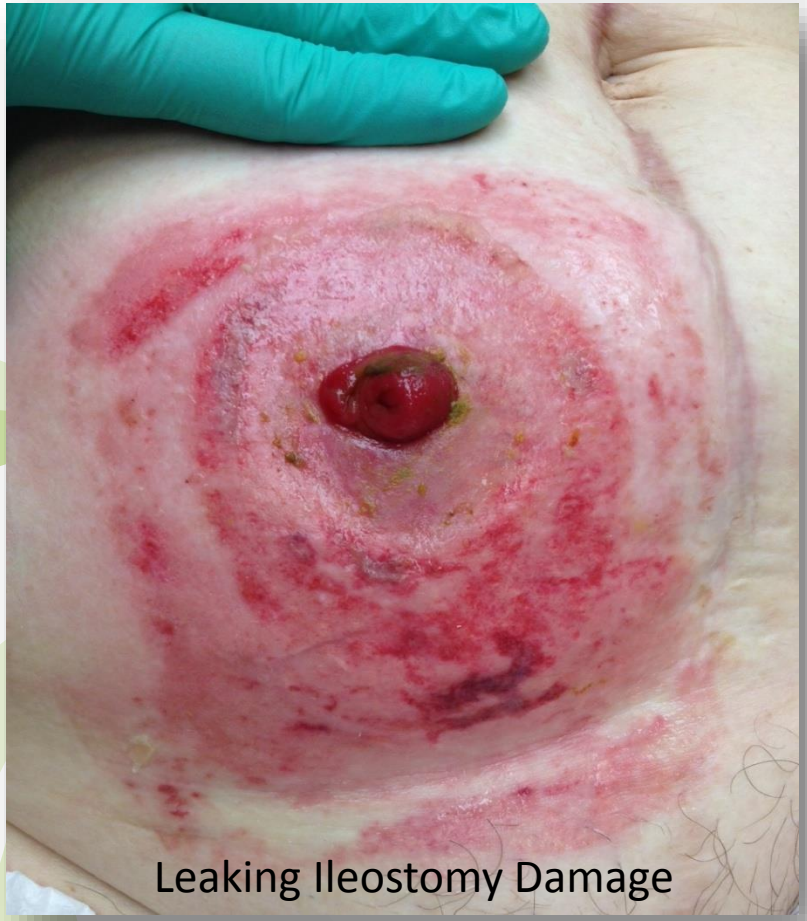
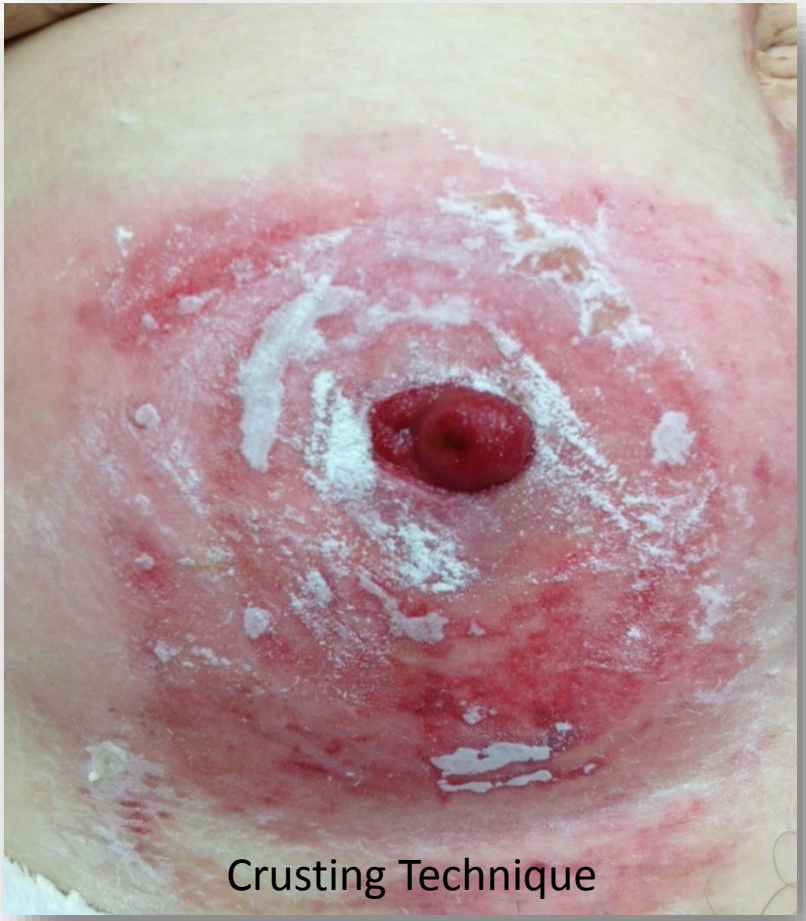


Irritant Contact Dermatitis.



Leaking Ileostomy Damage

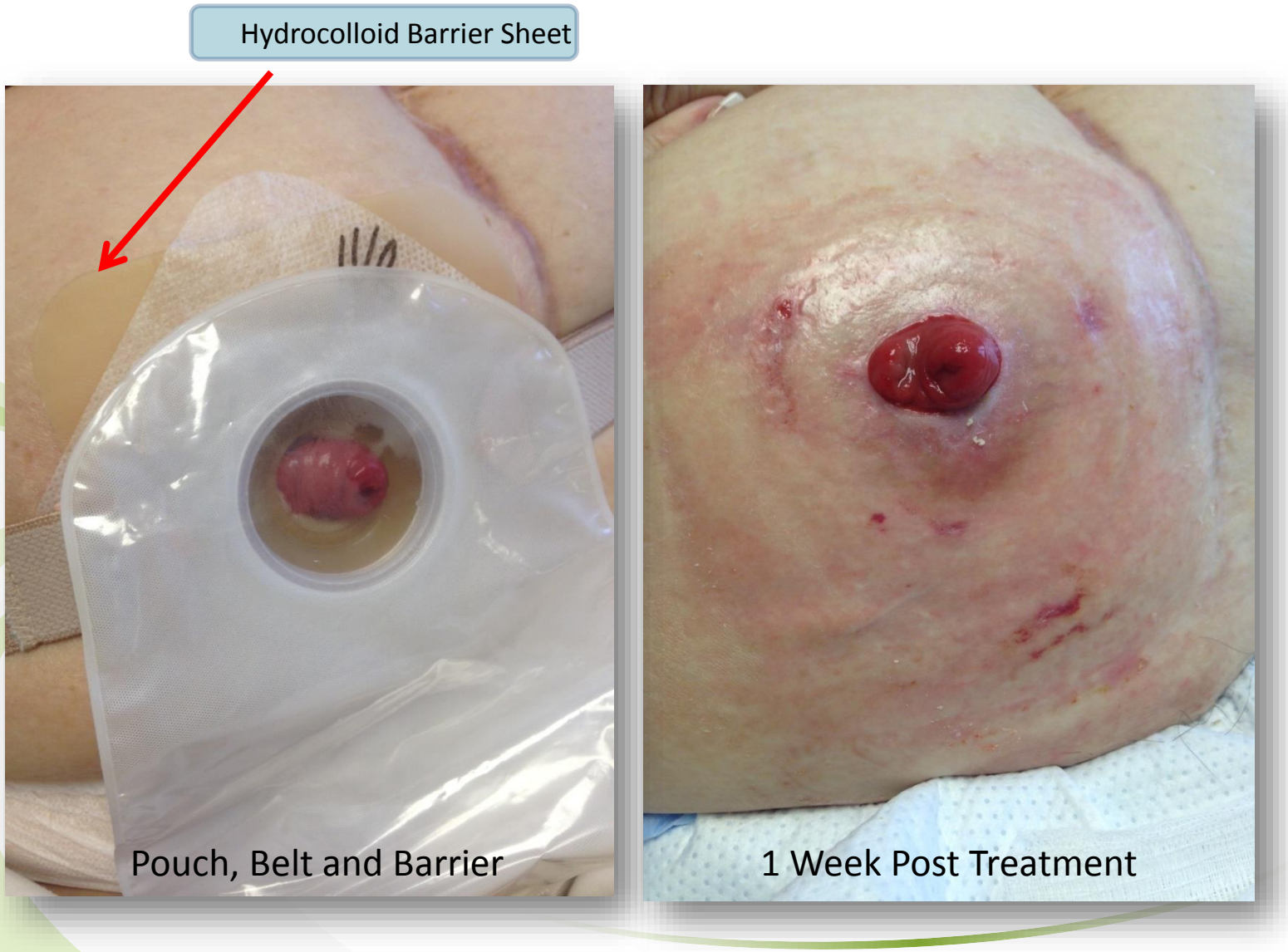


Crusting Technique

Astringent Soak.

- **Domeboro's (Burrows Solution)**
  - Temporarily relives skin irritation
  - Wet Compress 15-30 minutes (up to q8 hours)

Hydrocolloid Barrier.

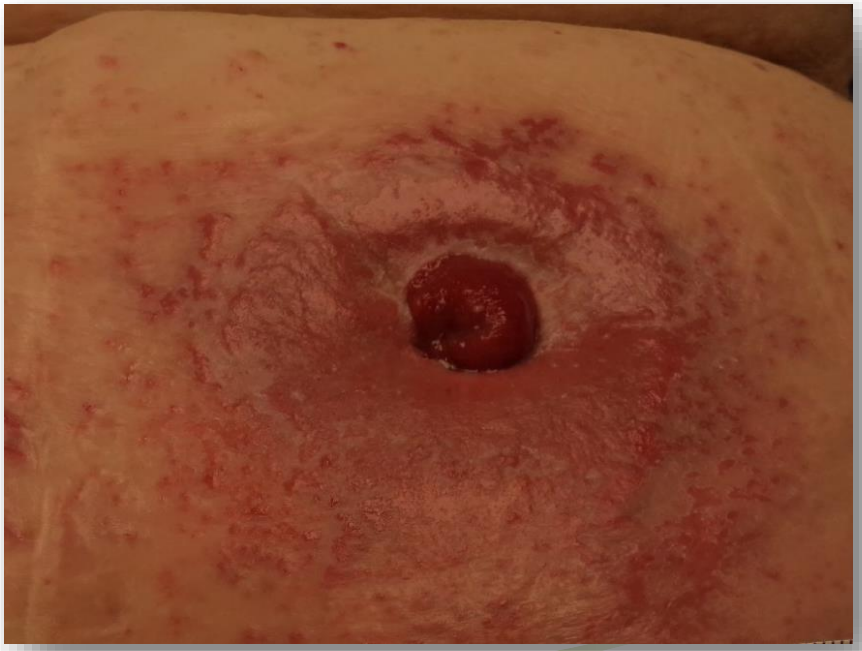


Peristomal Candidiasis.

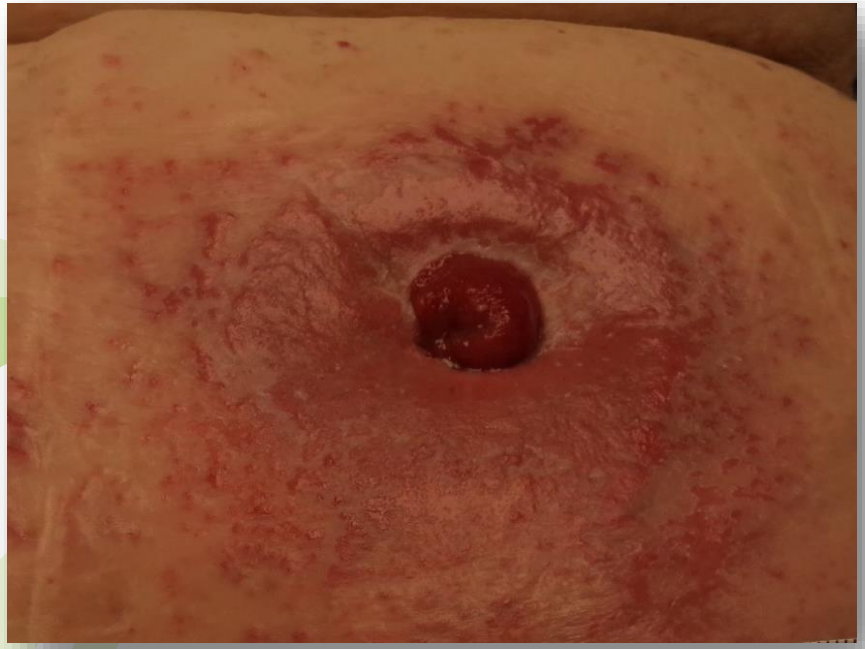
Cause/Presentation:

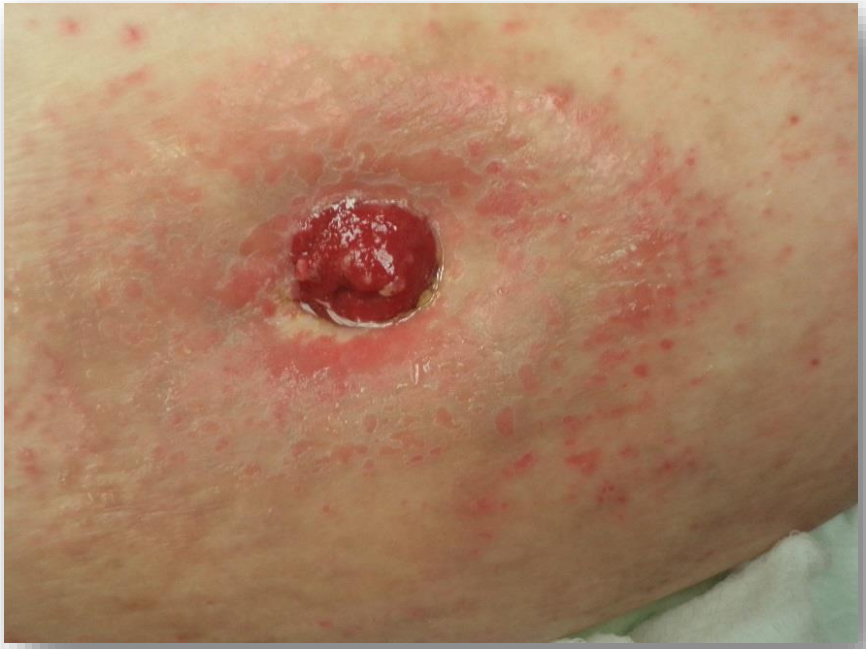
- Associated with ABX therapy
- Moisture
- Maculopapular rash with satellite lesions
- Pruritis

- *Treatment:*
  - Antifungal Powder
  - prescription, Nystatin
  - OTC , Miconazole 2%



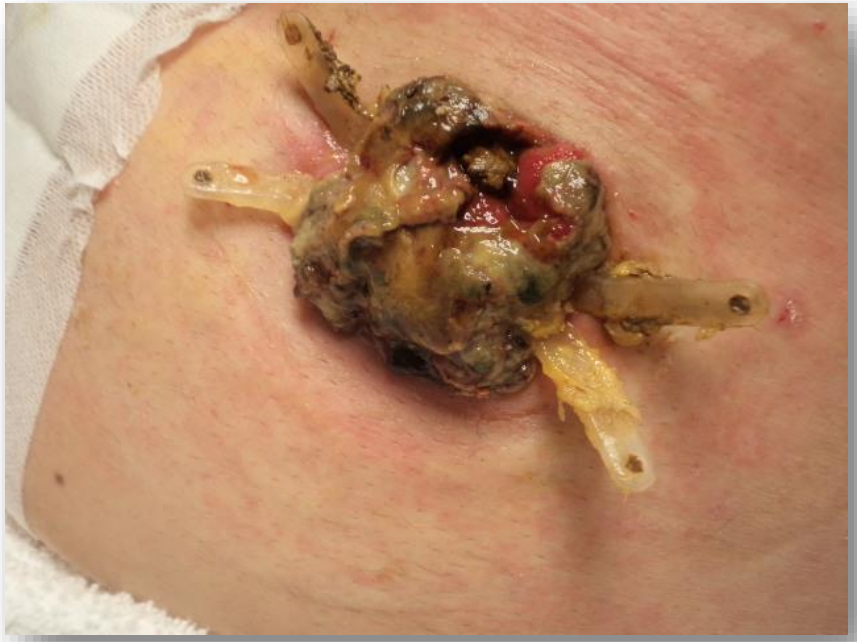
Peristomal Candidiasis.



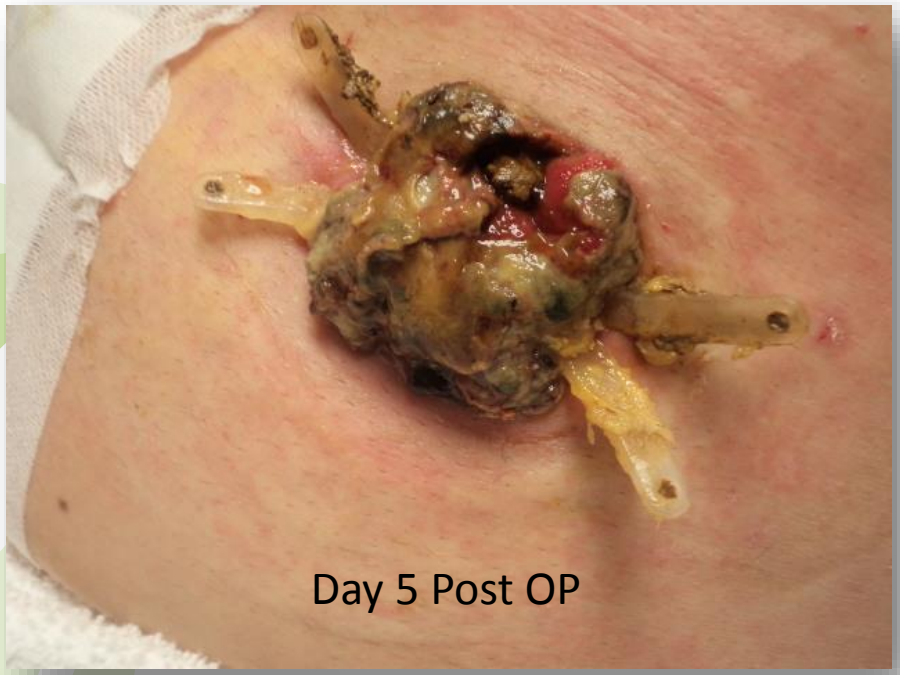


Necrosis and pouching a bridge.

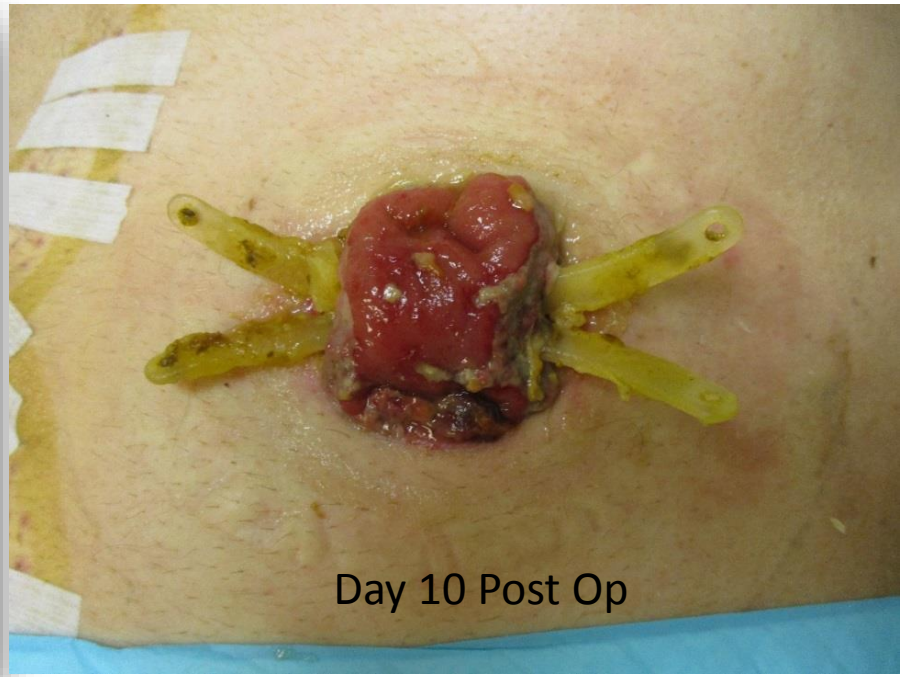
- ***Cause/Presentation:***
  - Death of mucosal tissue
  - Change in color, turgor, hydration
  - 72 hours to post-op
- ***Treatment:***
  - Monitor closely
  - Notify Surgeon if deeper necrosis is suspected
  - Control Odor



Stomal Necrosis with Bridge.

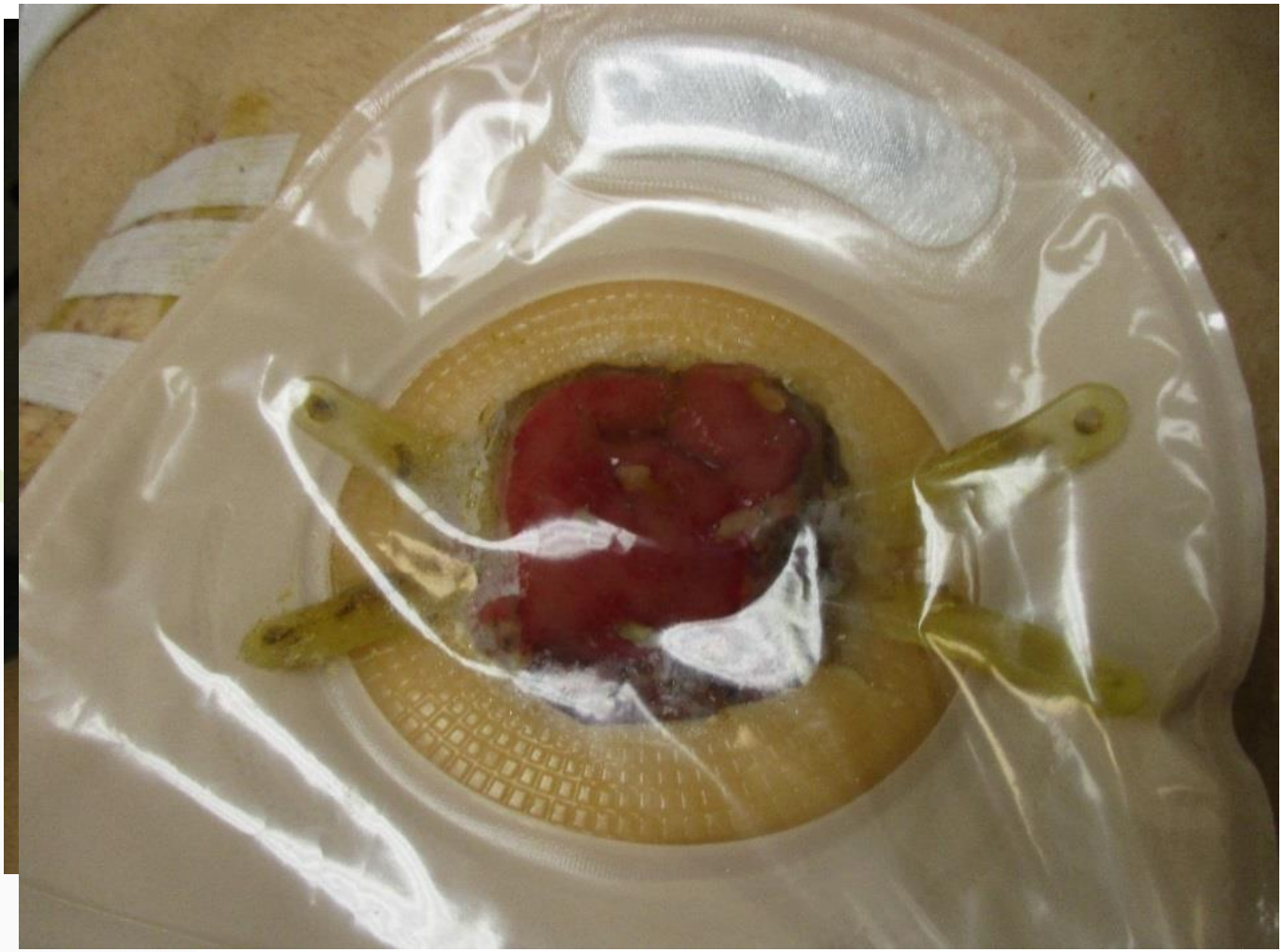


Day 5 Post OP



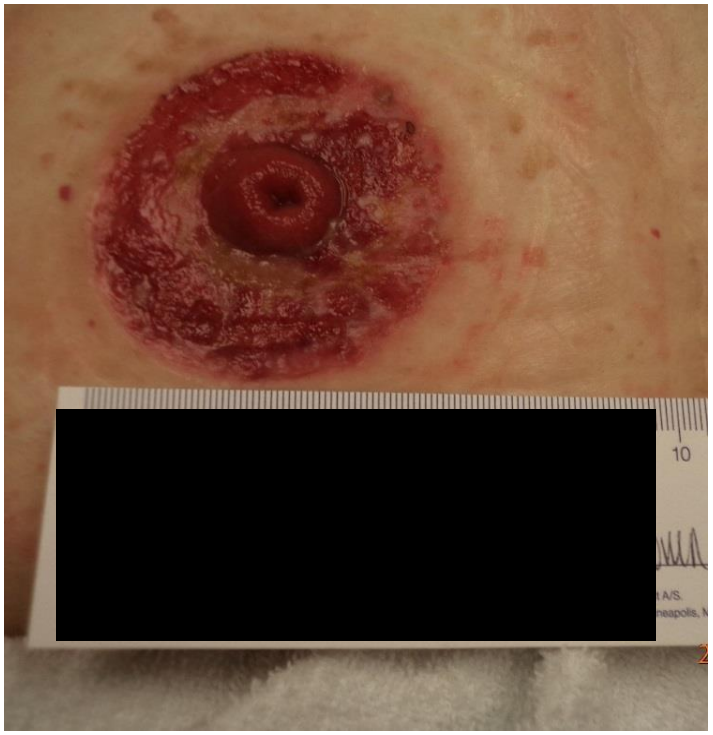
Day 10 Post Op

Pouching a Bridge.



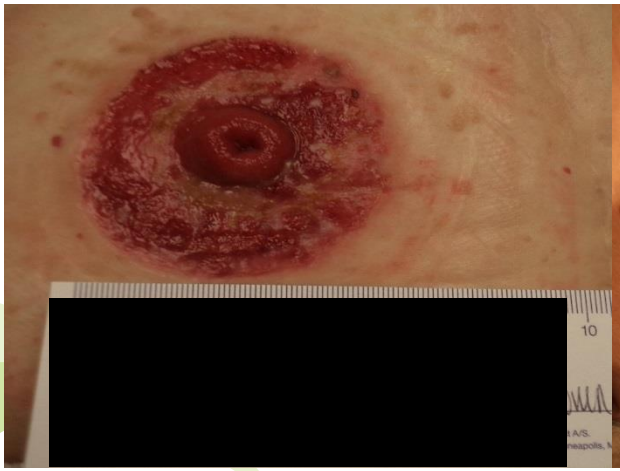
Allergic Contact Dermatitis.

- ***Cause/Presentation***
  - Rash that mirrors area of contact
  - Blister formation
  - Pruritis
  - Burning and pain
- ***Treatment:***
  - Eliminate allergen
  - Patch test
  - Topical steroids (Kenalog Spray)
  - Crusting
  - Absorbent dressing with hydrocolloid
  - After testing changed product

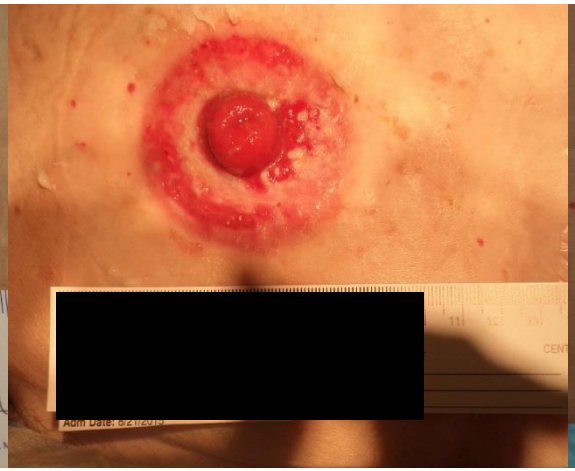


Allergic Contact Dermatitis.

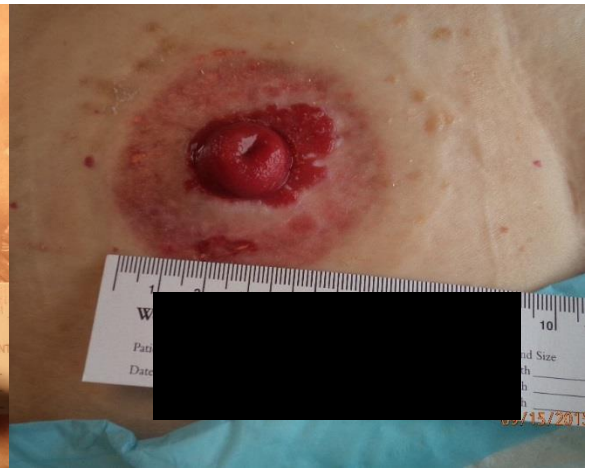
Initial presentation



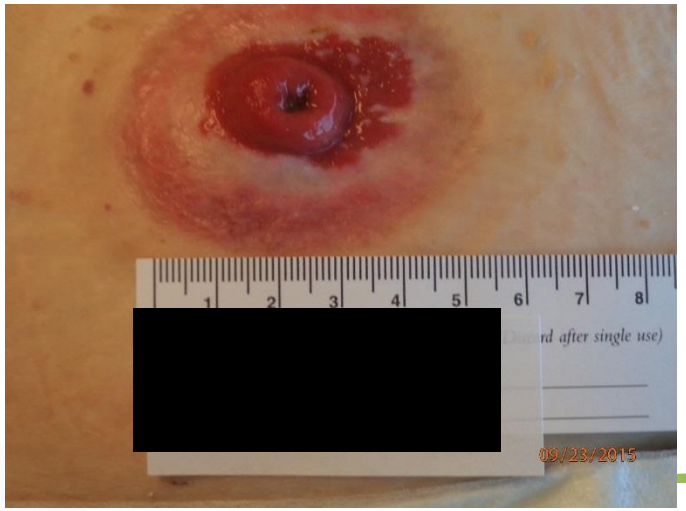
4 Days



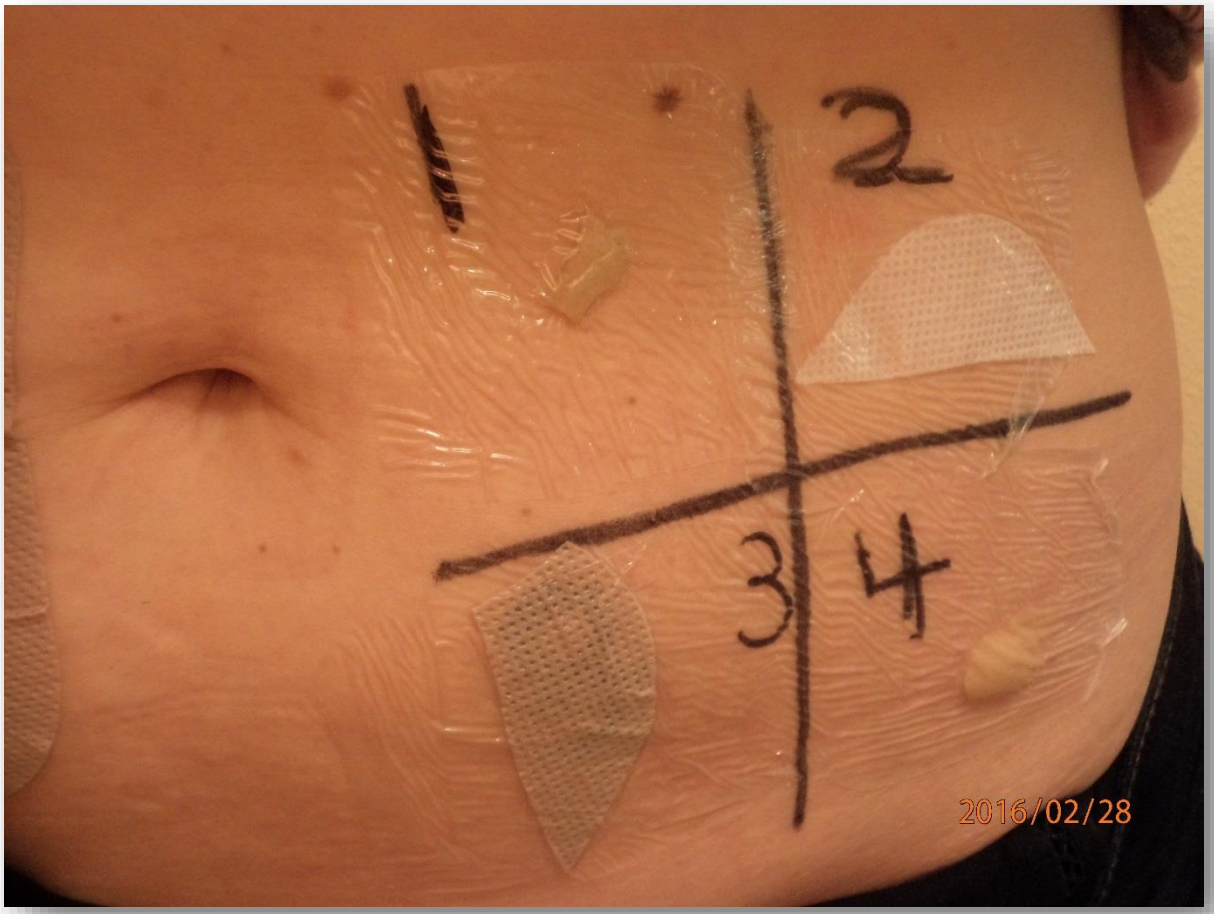
2 weeks



3 weeks

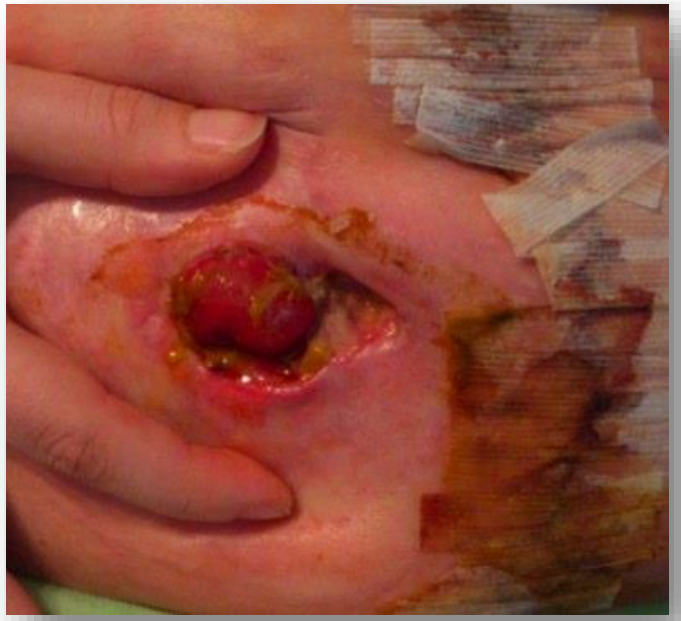


Patch Test.

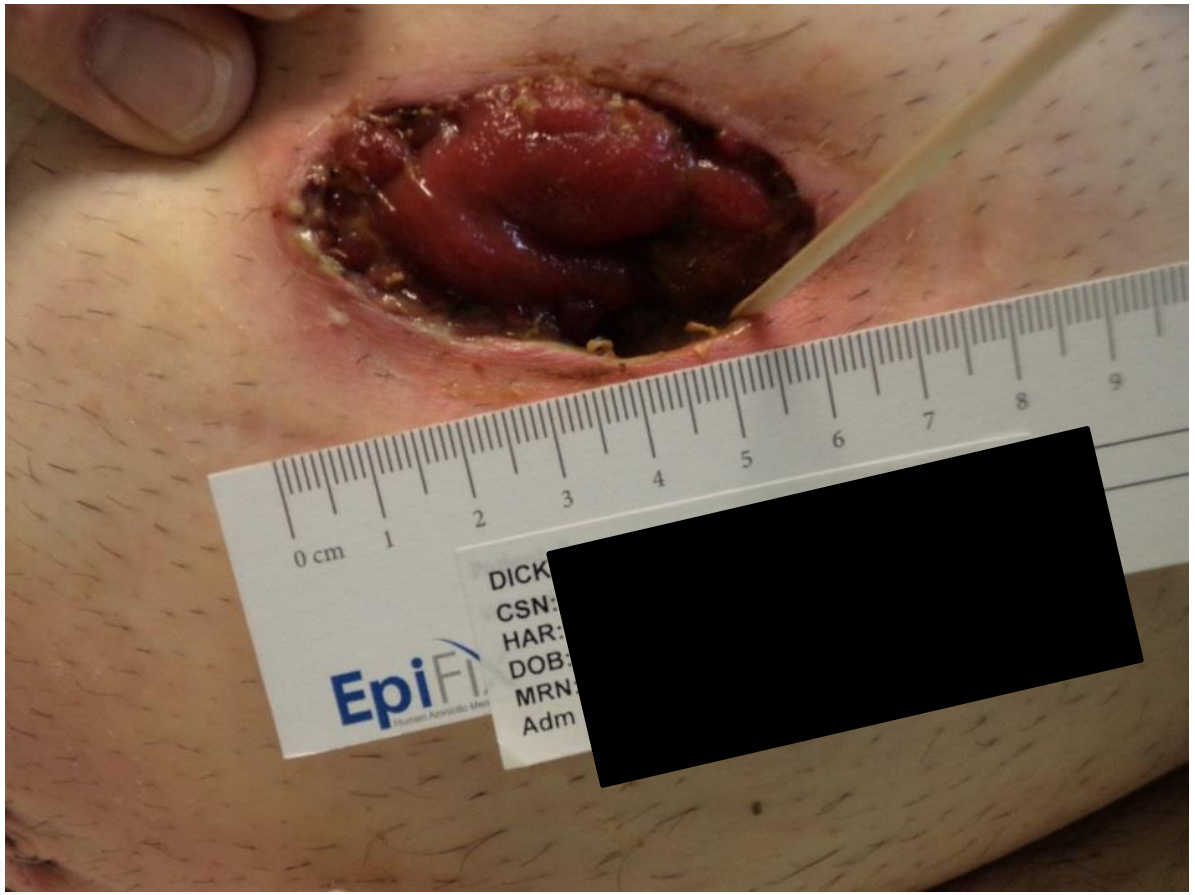


Mucocutaneous Separation

- **Cause/Presentation:**
  - Separation of stoma from peristomal skin
  - Tension at suture line
  - Poor wound healing
  - Risk for stenosis
- **Treatment:**
  - Moist wound healing and appropriate pouching
    - Hydrofiber
    - Hydrocolloid
    - Absorptive powder

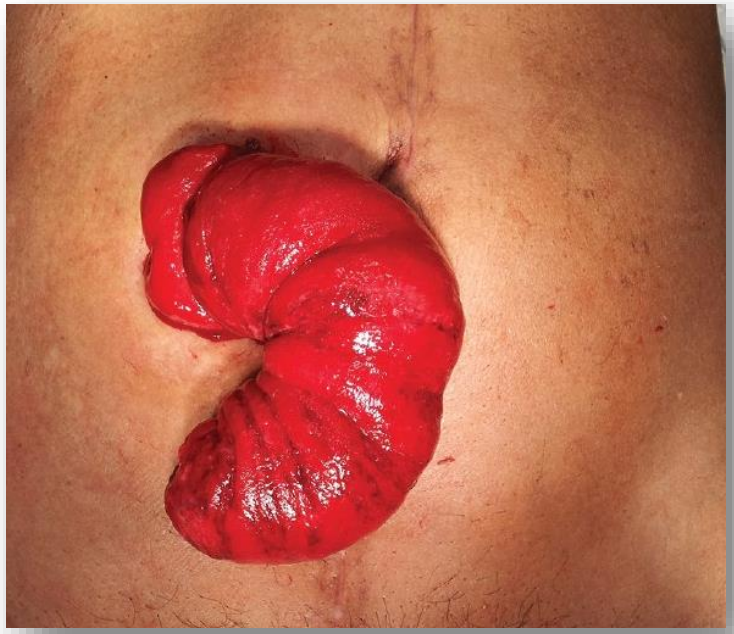


Mucocutaneous Separation.

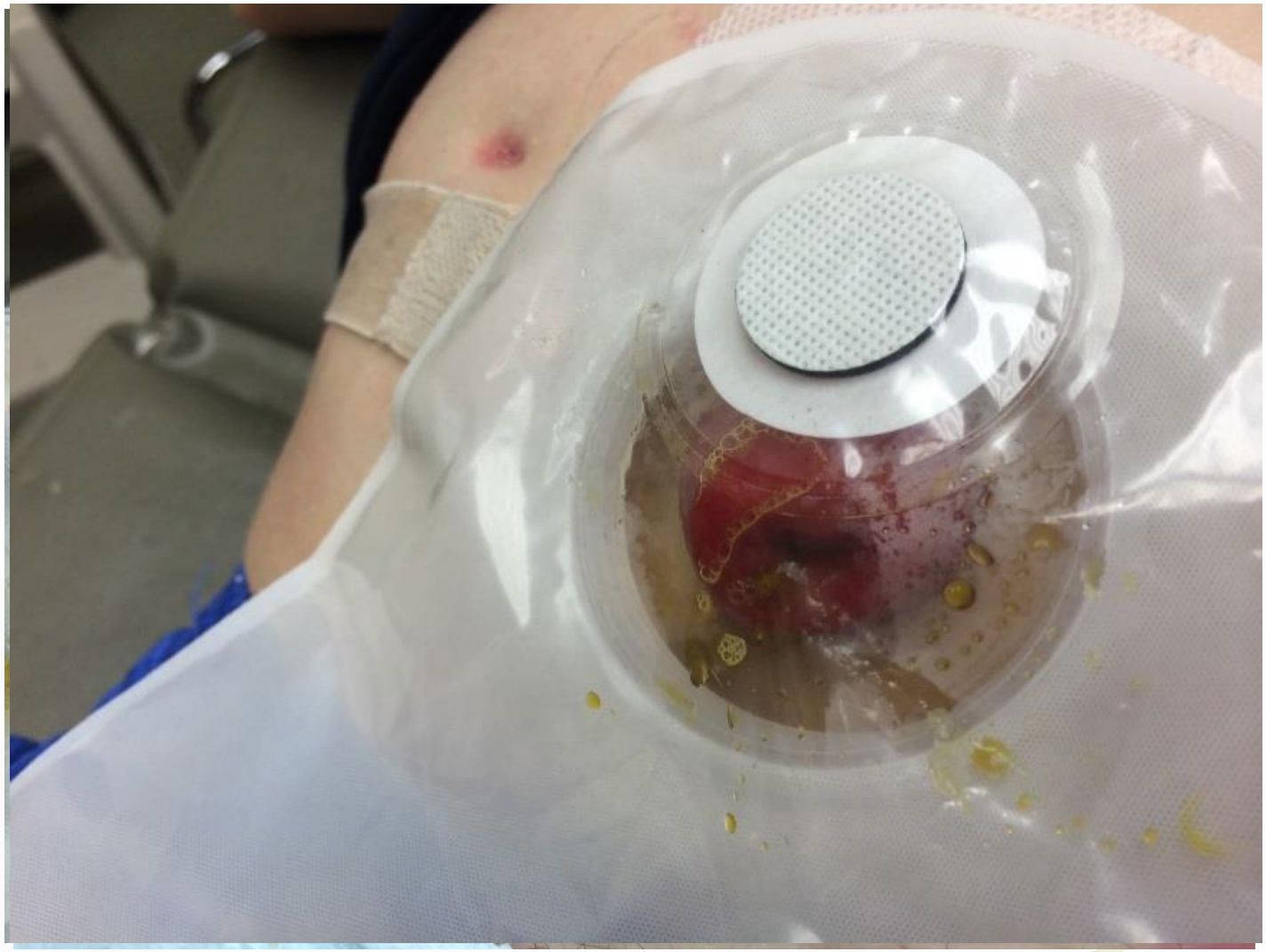


Pouching a Prolapse.

- ***Cause/Presentation:***
  - Displacement of stoma position
  - Loop Ostomy
  - Lack facial support
  - Obesity
  - Poor muscle tone
- **Treatment/Management:**
  - Manage edema
  - Ensure mucosal health
  - Ensure comfort with pouching
  - Prolapse belt

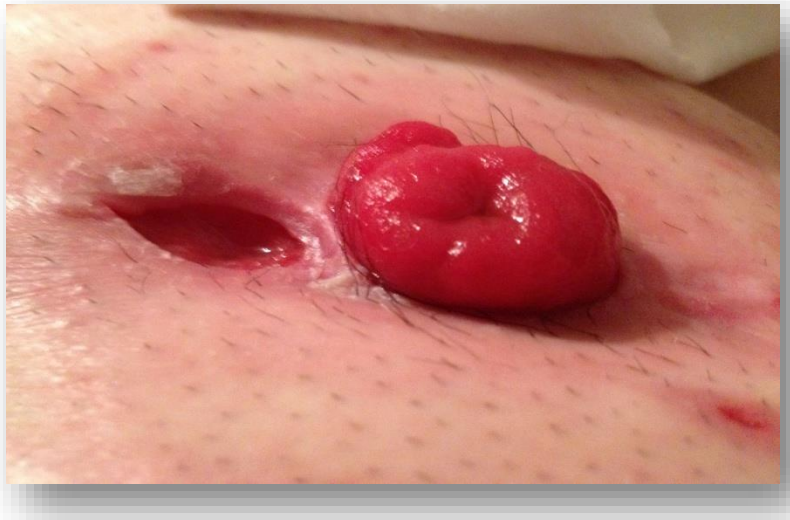


Pouching a Prolapse.



Peristomal Pyoderma Gangrenosum.

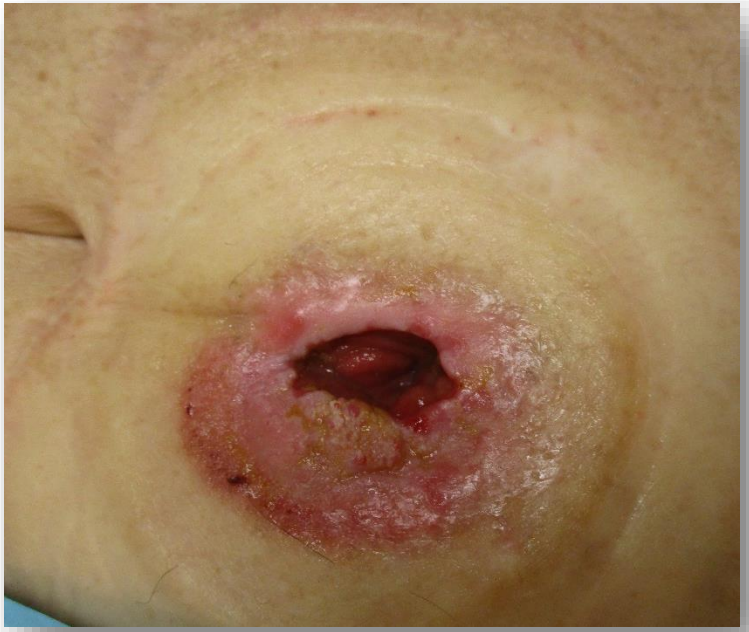
- **Cause/presentation:**
  - IBD
  - Autoimmune
  - Hepatitis
  - Exclusionary testing
  - PAIN
  - Crater formation
  - Violacious discoloration



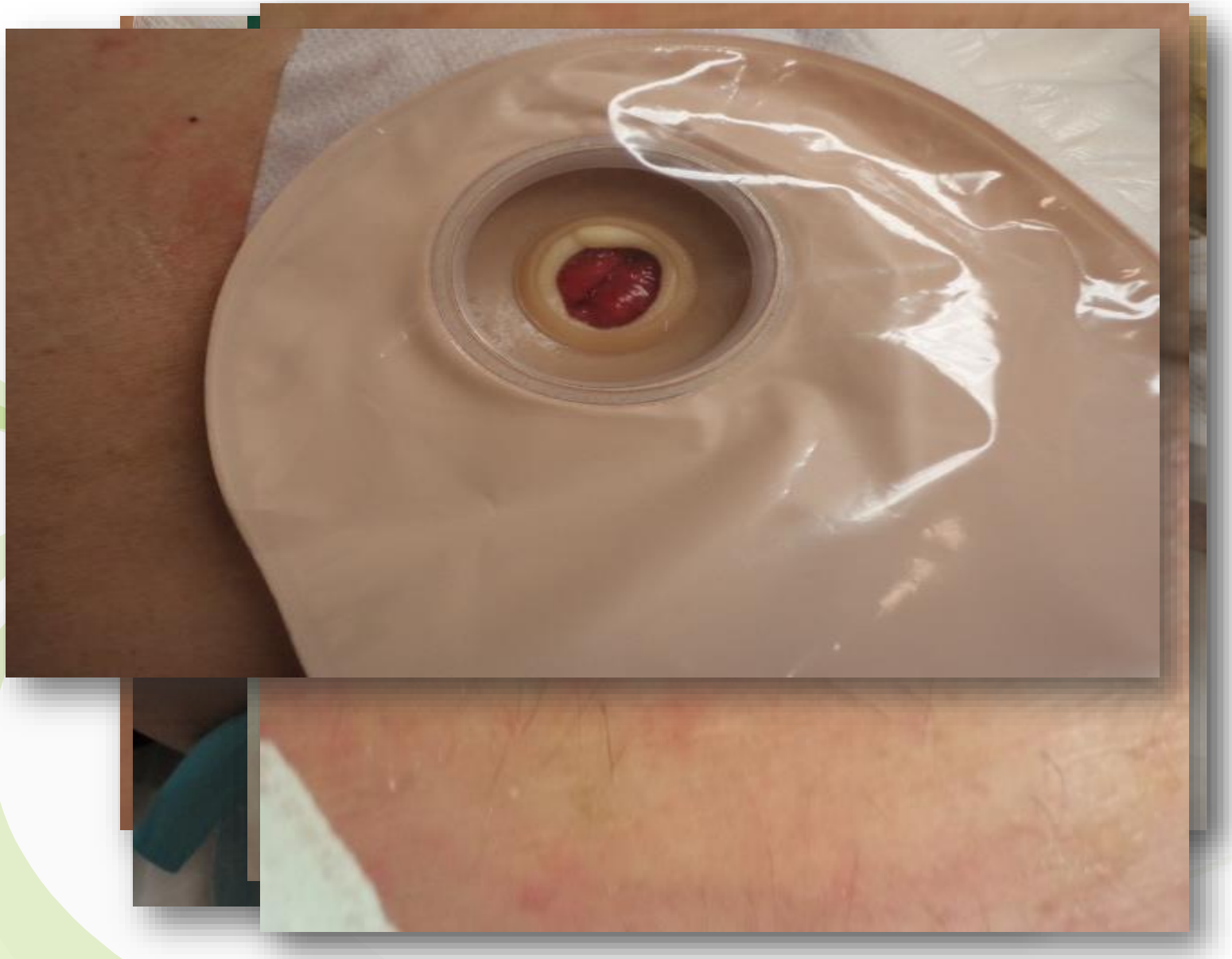
- **Treatment:**
  - ***Steroids!***
  - Atraumatic moist wound healing (pathergy)
  - Topical analgesics

Pouching a Retracted Stoma.

- ***Cause/Presentation:***
  - Stoma below skin layer
  - Tension
  - Post -op necrosis
  - Thick abdominal wall
  - Weight gain
- ***Treatment:***
  - Convexity
  - Flat flexible
  - Belting

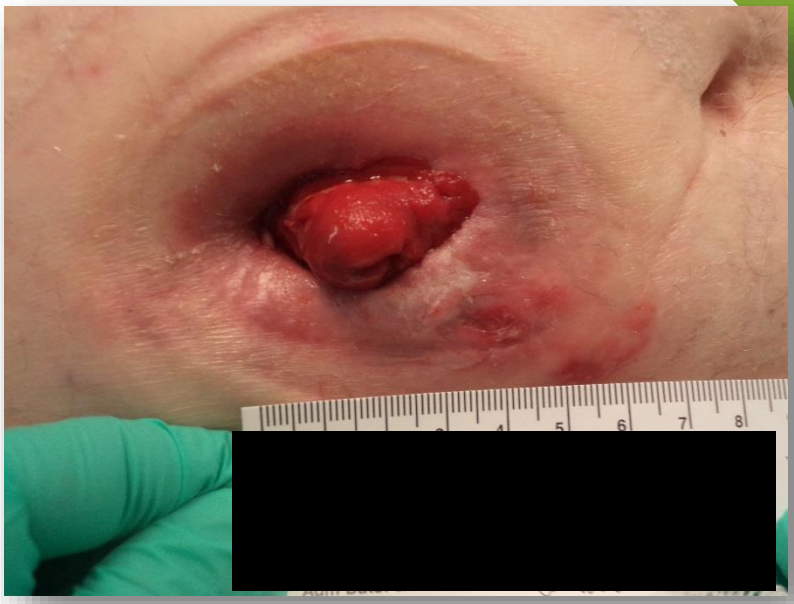


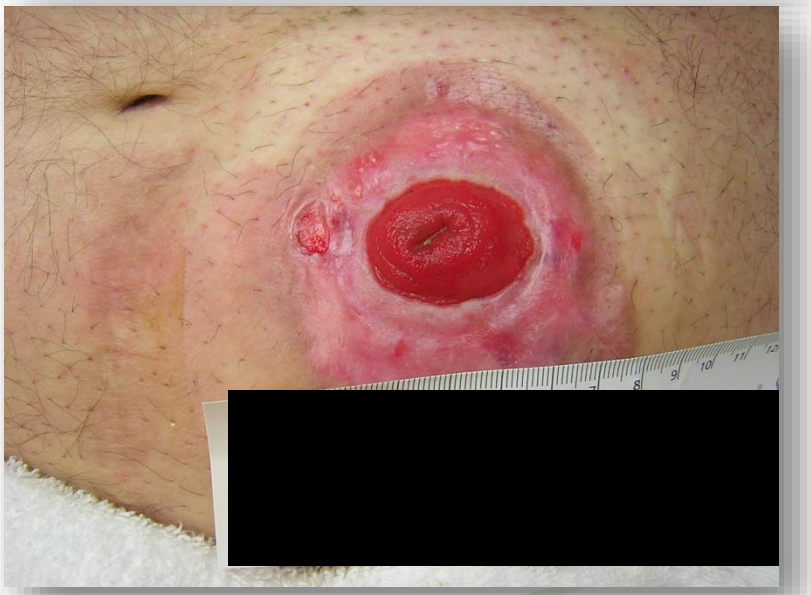
Retracted Stoma.



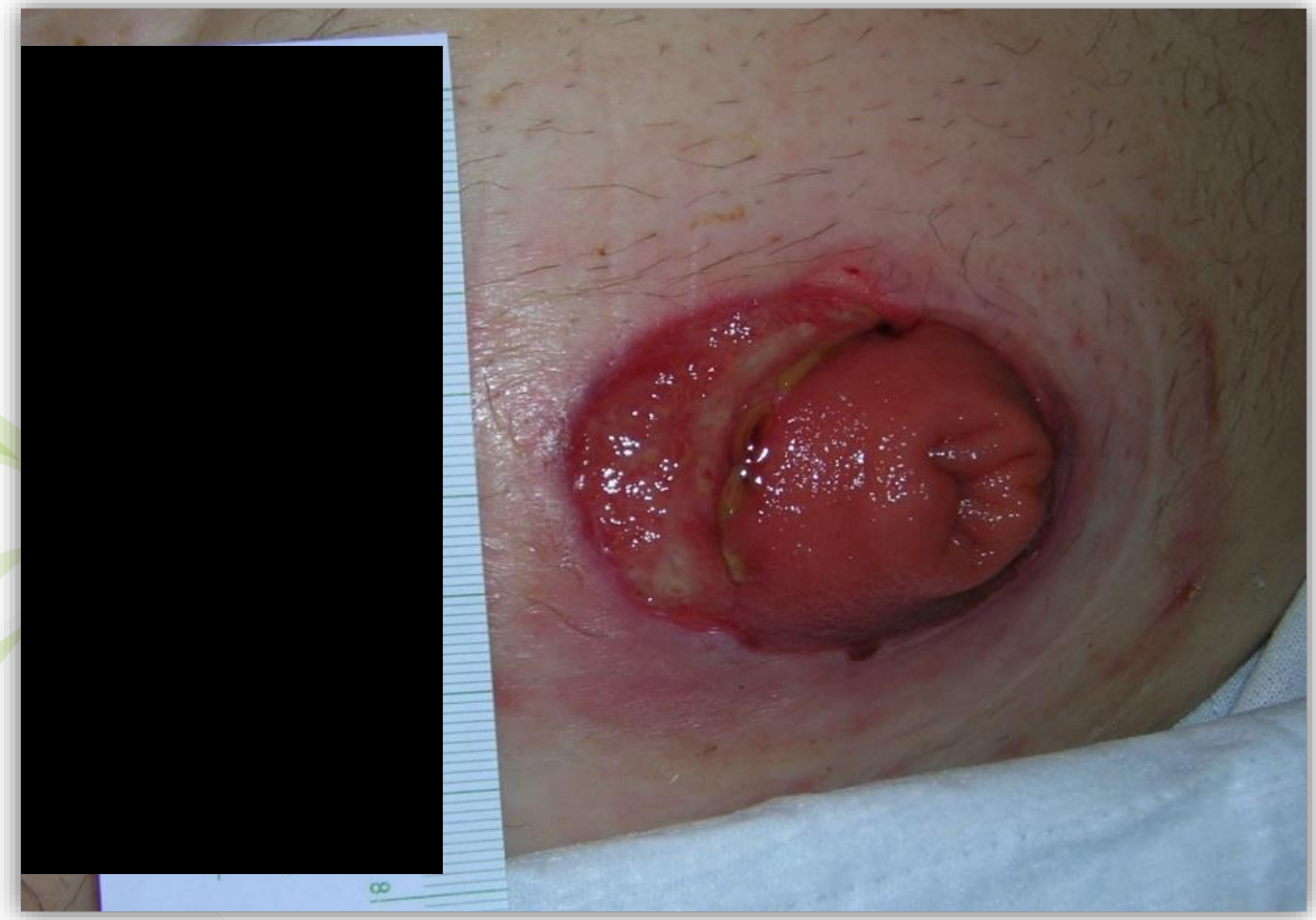
Pressure Injury.

- ***Cause/Presentation:***
  - Punctuate lesion
  - Pain under wafer
  - Rigid or convex wafer
  - Hernia
- ***Treatment:***
  - Reduce pressure
  - Hernia belt w/ soft oprning
  - Flexible pouching system





Pressure Injury.



Last thoughts ….

- **If in doubt …**
- **If treatment doesn't respond…**
- **Celebrate the successes ….**
- **Know when to speak truth ….**

References

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