TOP 10 THINGS YOUR PATIENTS WISH YOU KNEW ABOUT OSTOMIES

DOT WEIR, RN, CWON, CWS
SARATOGA HOSPITAL CENTER FOR WOUND HEALING AND HYPERBARIC MEDICINE
SARATOGA SPRINGS, NEW YORK

1

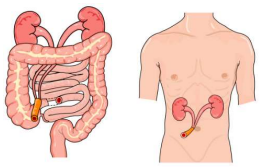
DISCLOSURES

- No disclosures relevant to this presentation

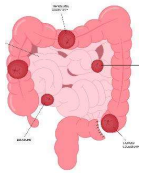
2

#10: WHERE IS STOMA PLACED IN THE BOWEL?

- Urostomy – length of ileum used, output obviously urine
- Bowel location determines type/volume output
  - Ileostomy—liquid to pasty (average output 1000 – 2000 cc/day) Liquid stool places at risk for dehydration, decreased nutrient absorption, breakdown of ostomy barrier, and leakage.
  - Colostomy—soft to formed stool
  - Loop vs. End stoma
  - Expected output may be different in the complex patient with multiple surgeries



TYPES OF OSTOMY



3

3

#9: PATIENT/FAMILY EDUCATION

- Pre-operative education ideal
  - Stoma marking
- Enhanced Recovery After Surgery (ERAS)
  - Earlier discharge
- Provide written information when able and available
  - Websites
  - Appropriate grade level
- Demonstrate/Return demonstration

4

4

#8: APPLIANCE MANAGEMENT

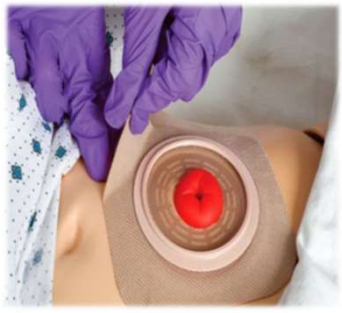
- Learn the basics
  - How to measure
    - Opening should be 1/16 – 1/8 inch away from stoma.
  - Use of skin wipes
  - Use of paste / rings
  - Skin intact underneath and around barrier.
  - Wear time 3- 7 days. Variable to patient situation.
  - At least 3 days = less invasive on QOL, less irritating to skin, consistent with insurance coverage.

5

5

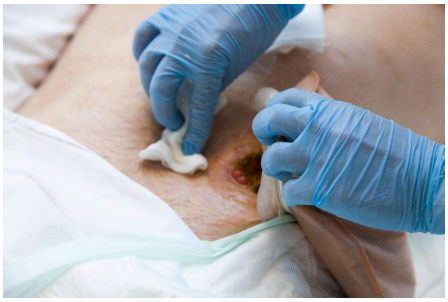
BASIC PROCEDURE

- Nuances
  - Plan for ideal time of day
    - OP visits first appointment of the day
  - Stomas are unpredictable
    - Have gauze close by
    - Keep your cool; patient will be upset/embarrassed/apologetic/ frustrated
  - Be aware of pain if present
  - Learning this is not “one and done”



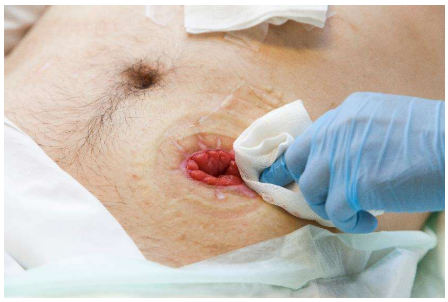
6

BASIC PROCEDURE



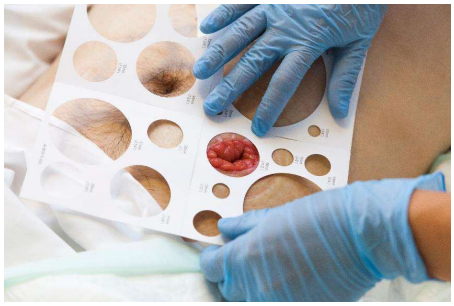
7

BASIC PROCEDURE



8

BASIC PROCEDURE

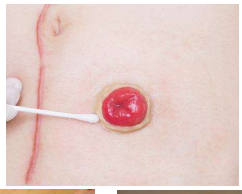


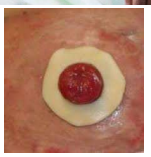
9

BASIC PROCEDURE

10

BASIC PROCEDURE

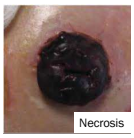




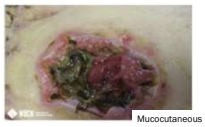
11

#7: COMPLICATIONS - STOMA

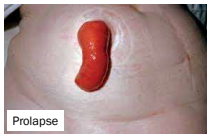
- Stoma
  - Early: Notify surgeon immediately
    - Necrosis
    - Mucocutaneous separation
  - Later: May need revision
    - Best to refer to WOC Nurse
    - Prolapse
      - See surgeon
      - Enlarge wafer opening
    - Retraction
      - See surgeon
      - Adapt pouching technique



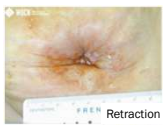
Necrosis



Mucocutaneous separation



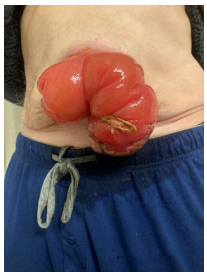
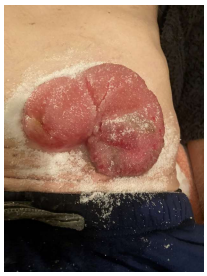
Prolapse



Retraction

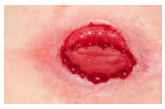
12

PROLAPSE


13

COMPLICATIONS - STOMA

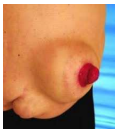


- Bleeding—From inside or surface of stoma?
  - History of liver disease?
  - Anticoagulation
  - Look at appliance fit
  - Gentle technique
  - Cautery
  - Topical hemostatic agents


14

HERNIAS

- Frequency 14 -70%
- Conservative management
- Re-evaluate appliance system
- Hernia support
- Patient education for obstructive symptoms

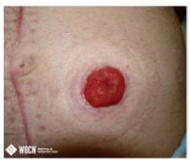


15

15

#6 COMPLICATIONS - SKIN

- Skin should be intact—no pain, burning or itching.



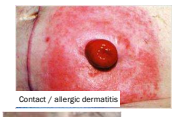
16

SKIN COMPLICATIONS

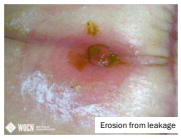
- Dermatitis
  - Contact or allergic
  - Ill-fitting appliance
- Fungal rash
- Folliculitis
  - Pulling hair with wafer removal
  - Shaving

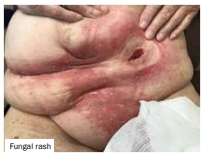

Folliculitis


Erosion from leakage


Contact / allergic dermatitis


Appliance opening too large


Erosion from leakage


Fungal rash

17

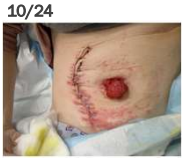
CASE STUDY: CAUSE NOT ALWAYS EVIDENT

- 38-year-old female
- Long history of Crohn's disease all small bowel
- Multiple surgeries related to disease and strictures
- 9/29 had exploratory lap
  - Extensive adhesiolysis > 3 hours,
  - Redo of ileocolic resection with stapled end-to-side anastomosis,
  - Intra-abdominal omental flap,
  - Takedown of internal fistula,
  - Small bowel resection without anastomosis,
  - Double barreled jejunostomy.

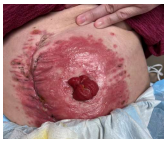
18

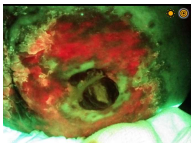
VISIT HISTORY

10/24



11/14

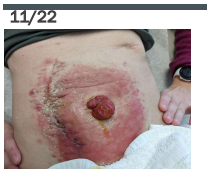




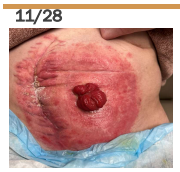
- Cultured at incision, grew staph aureus and pseudomonas
- Started on doxycycline and ciprofloxacin liquid

19

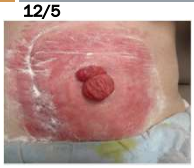
11/22



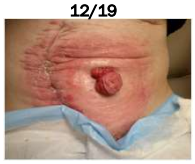
11/28



12/5



12/19

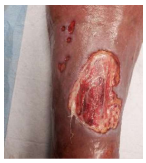


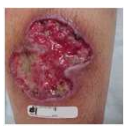
- Began to get worse again, consulted surgeon to assess keeping her on Doxy and Cipro until closure which was approved
- 11/28 Added Karaya powder to improve pH (4.5-4.7)
- She cleared and had closure surgery in January

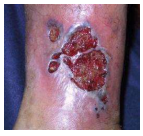
20

PYODERMA GANGRENOSUM

- Later skin ulceration usually in patients with autoimmune disease
  - Inflammatory bowel disease (ulcerative colitis and Crohn disease)
  - Rheumatoid arthritis
  - Myeloid blood dyscrasias including leukemia
  - Monoclonal gammopathy (usually IgA)
  - Chronic active hepatitis
  - Granulomatosis with polyangiitis
  - PAPA syndrome (Pyogenic Arthritis, Pyoderma Gangrenosum, Acne)
  - Behçet disease
  - Use of levamisole-adulterated cocaine
  - Miscellaneous less-common associations
  - May be no obvious reason
- Seen more commonly on lower extremities



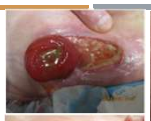
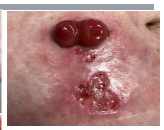


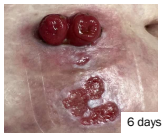


21

PERISTOMAL PYODERMA

- History of triggering disease
- No other explanation for ulceration
  - Ulcerations are deeper than typical skin erosion
  - Usually exquisitely painful
- Treatment is medical: both systemic and topical
  - Tapering steroids
  - Cyclosporine if no response
  - Topical steroid spray, crushed tablets, tacrolimus
- Need to cover, absorb and protect from appliance wafer

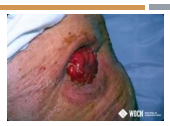
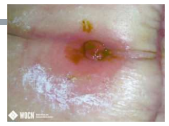
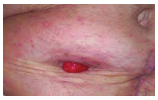


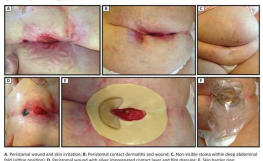
Photos courtesy of Hadar Lev Tov, MD

22

5: LEAKAGE PROBLEMS

- Common reasons
  - Change in abdominal contour
  - Weight gain or loss
  - Stoma in skin fold or near umbilicus or scar
  - Stomal retraction

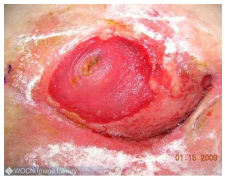




23

#4: CRUSTING SKIN

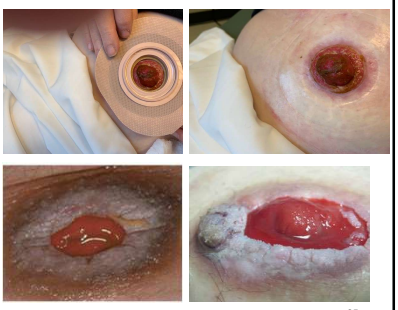
- Cleanse skin well with soap and water, pat dry
- Use pectin powder, antifungal powder or karaya powder depending on availability and need
- Sprinkle powder liberally to irritated / moist areas of skin, dust away the excess
- Spray non-stinging polymer spray over powdered area.
  - If wipes are only delivery method available, blot (DON'T WIPE) over powdered area
- Allow to dry completely, if skin still seems moist repeat the procedure.
- Powdered area should feel dry to the touch



24

#2: COMMON MISTAKES

- Barrier opening too large or small
  - Not adjusting for stoma shrinkage
  - Crust skin and remeasure stoma
  - To treat urine crystals, use dilute acetic acid soak then cleanse skin
- No creams/ointments under the barrier.
- Patch test spray adhesive products



25

25

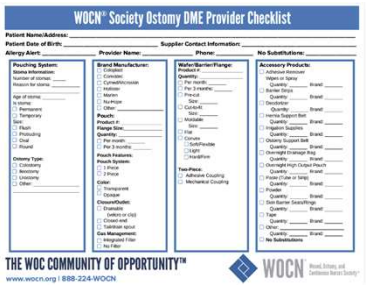
#3: WHERE AND HOW TO OBTAIN APPLIANCES

- Most insurers follow Medicare guidelines.
- Prescription needed for insurance coverage.
- Can be purchased out of pocket.
- Over supplies can be authorized with LMN and follow-up.
- Are prescriptions written for amounts that are covered?

26

26

PROVIDE SPECIFICS



27

#2: RESOURCES

- UOAA—great dietary resource https://www.ostomy.org/diet-nutrition/
- CCFA: https://www.crohnscolitisfoundation.org/
- Manufacturers often employ WOC nurses who assist people over the phone with supply questions.
- Hollister: 888-808-7456 https://www.hollister.com/en/ostomycare
- Convatec: 800-422-8811 https://www.convatec.com/products/ostomy
- Colopast: 888-726-7872 https://products.coloplast.us/products/ostomy-care/
- Wound, Ostomy and Continence Nurses Society (WOCN) https://www.wocn.org

28

28

RESOURCES

29

29

#1: QUALITY OF LIFE

- Resumption of:
  - Diet—low-residue bland diet for 6 weeks, then normal with some caveats
  - Normal activities—resume in 6 weeks (surgeon's direction)
  - Sexual activity—resume depending on procedure (surgeon's direction) and when comfortable
  - Travel – plan ahead
    - Changes in diet
    - Traveling with supplies (scissors)

30

30

QUALITY OF LIFE

- People with stomas can live normal lives.
- Everyone adapts differently.
  - They are not defined by their surgery
- For many having lived with a devastating disease it is truly a new lease on life
- They don't have to love it, but they will learn live with it

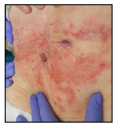
31

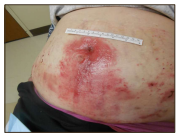
LET'S SWITCH GEARS..

32

FISTULAS

- An abnormal opening or passage between two organs or between an organ and the surface of the body.
  - May be caused by injury, infection, or inflammation, or may be created during surgery.
- Most commonly seen is an enterocutaneous fistula
  - Connection between bowel (usually small) and skin

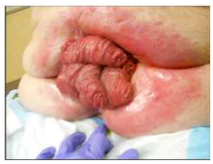




33

FISTULAS

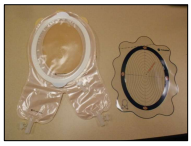
- Negative Prognostic Factors (FRIENDS)
  - **F**oreign body
  - **R**adiation enteritis
  - **I**nflammatory bowel disease
  - **E**pithelialization of the fistula tract
  - **N**eoplasm
  - **D**istal Obstruction
  - **S**epsis
- Goals of Management (SNAPS)
  - **S**kin and sepsis
  - **N**utrition
  - **A**natomy of the fistula
  - **P**roposing a procedure to address



34

LOCAL MANAGEMENT OF FISTULAS

- Primary goal is protection of skin and containment of output
- Treatment should be immediate; delay exacerbates skin problem
- High-output pouches have drains that can be connected to wall suction or gravity drainage bags for large fecal output
- Pediatric pouches helpful for low output

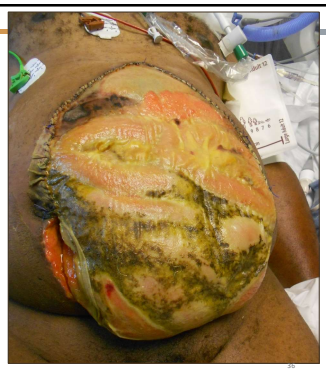


35

35

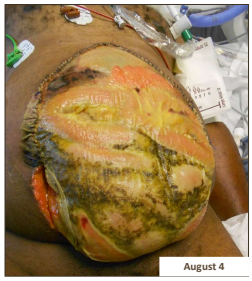
CASE

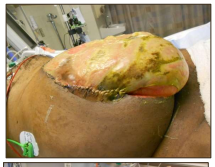
- S/P nephrectomy
- SBO
- Multiple PE arrests
- Compartment syndrome
  - Decompressive enterotomy
- Vicryl mesh to skin edges over exposed bowel

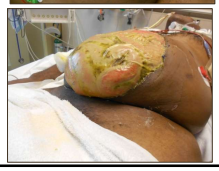


36

VICRYL MESH TO SKIN EDGES – NO FISTULA…YET

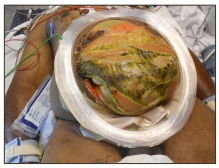


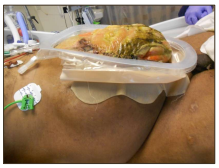




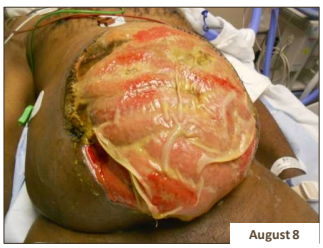
37

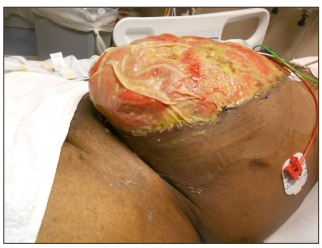
POUCH TAILORING





38





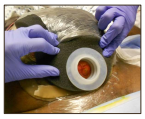
39

OPEN ABDOMEN DECISION-MAKING TO NPWT OR NOT

Inflamed bowel → Sutures Injuries → Moist wound healing and pouch

NO NPWT

Bowel and host healthy → Granulation tissue in wound → Loops of bowel hidden

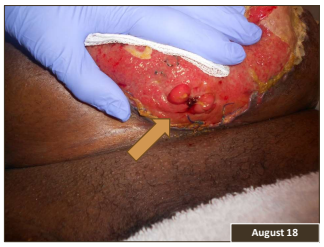


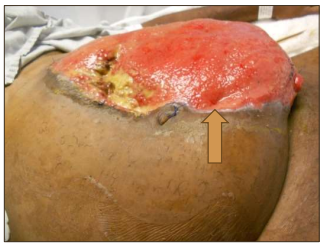
NPWT and isolate

40

40

IDENTIFICATION OF FISTULA

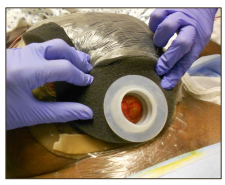


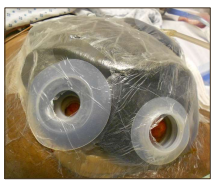


41

41

NPWT WITH BOWEL ISOLATION DRESSING

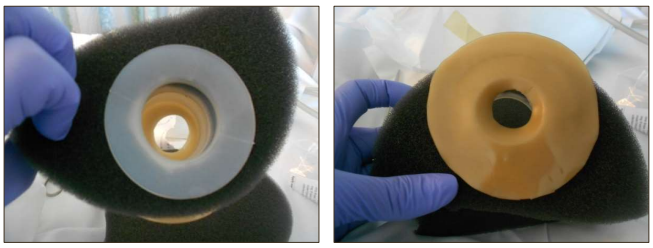




Beginning fistula journey

42

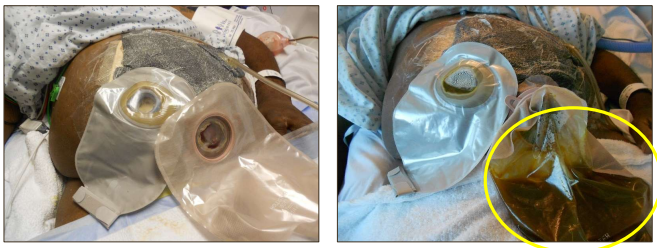
42



43

43

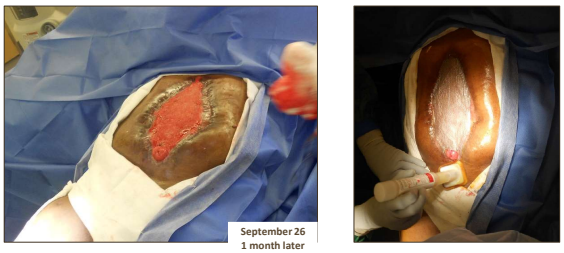
ASSESSMENT OF FISTULA ACTIVITY



44

44

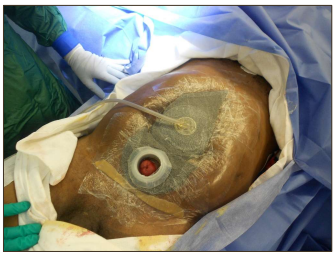
PARTIAL THICKNESS SKIN GRAFT

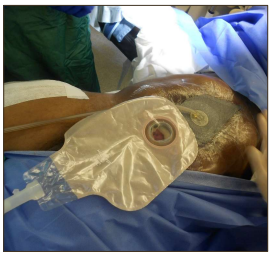


45

45

GRAFTING AND HIGH OUTPUT POUCH

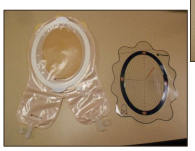




46

46

POUCHES: NOT ALL THE SAME

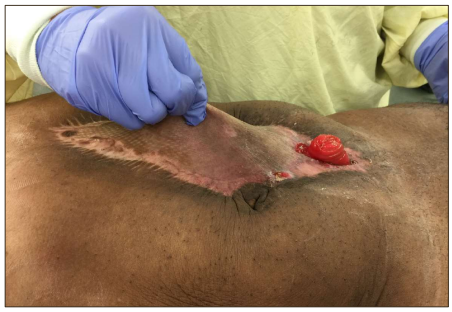


High-output pouches have drains that can be connected to wall suction or gravity drainage bags

47

47

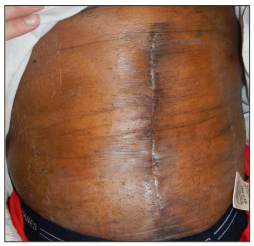
READY FOR SURGERY!

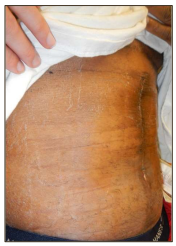


48

48

GRADUATION PICTURE





January

49

49

MEET MY VERY SPECIAL PATIENT

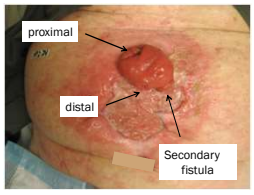
Permission received from patient and his family to use his actual picture in educational presentations. To see him was to love him.

- 87 years old
- Severe RA
- Ischemic bowel after CAGB surgery resulting in bowel resection in 2004
- Post-op anastomotic leak, wound infection, large fistula
- History of **SIX** years daily home care nursing visits, dressing changes
- Constantly wet, soiled, malodorous
- Quality of life non-existent, depressed, wouldn't leave house
- Sent to me by home care to "please help"!!

50

THIS WAS HIS WOUND

- This is not a loop colostomy
- Arrows identifying areas of stool production
- Skin constantly irritated
- Everything had been tried
- His confidence in us was very low



51

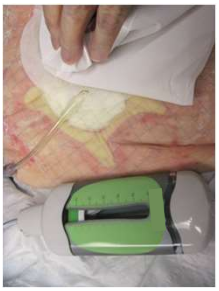
SAWC SPRING 2010

- We weren't doing much better
- Still not dry longer than 48 hours
- Got a tip in the poster presentations to see the new MPNPWT product
- It changed everything

52

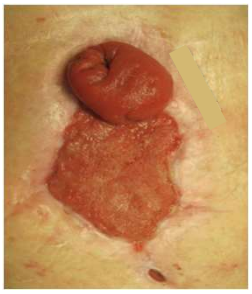
WE BECAME CREATIVE....

- No real references at that time
  - Clinical trial was in progress; but just DFU's and VLU's
- *Ostomy* and wound nurse
  - Combining pectin products just made sense
  - Quality of life improvement for him
  - Home care visits dropped to 1 x week
  - Dignity & Cleanliness
  - Desire to leave the house
  - Twice a week visits became special outings with son



53

THEN WE MADE IT WORK



54

SUMMARY

- Caring for ostomy patients, or any patient requiring a pouch can be intimidating and frustrating but, in the end, very rewarding
- It is a skill level that can be taught and fine tuned
- Seek out the information
- Use your support options

55