Ostomy Care Techniques

Jessica Salgado RN, BSN, CWOCN
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OBJECTIVES

• Review the essential components of patient/stoma assessment.

• Discuss common complications related to ostomy care.

• Discuss pre-operative and post-operative patient education and preparation.
STOMA ASSESSMENT

- **Location** – Ex: Right Lower Quadrant ABD

- **Color** – pink, red, rose, brick red

- **Shape** – round, oval, irregular

- **Tissue edges** – intact, muco-cutaneous separation
STOMA ASSESSMENT (CONTINUED)

- Protrusion – moderate, flush, retracted, prolapsed
- Moisture – moist, shiny
- Presence of a surgical bar
- Presence & amount of bleeding with stoma care
STOMA-RELATED COMPLICATIONS

“Early” Complications
- Mucocutaneous separation
- Stoma necrosis
- Retraction

“Late” Complications
- Stomal stenosis
- Stoma prolapse
- Stomal laceration
- Parastomal Hernia
MUCOCUTANEOUS SEPARATION

• Etiology:
  – Compromised healing at the mucocutaneous suture line

• Risk Factors:
  – Patients on steroids
  – Immune suppressed
  – Diabetes
  – Hx of radiation
  – Malnutrition or Obesity

• Assessment:
  – Location of defect
  – Assess for depth and extent of defect

Image taken from: www.almediaweb.jp
MUCOCUTANEOUS SEPARATION TREATMENT

Fill in space with:

- Powder & seal in powder with skin protectant
- Paste (Use caution. Patients may report “burning pain” - product contains alcohol)
- Alginate (Use hydrocolloid dressing as a secondary dressing)
- Hydrofera Blue (May use hydrocolloid dressing as a secondary dressing)

Fit the skin barrier to fit over affected area
NECROSIS

• **Assessment**
  – A section or entire stoma may appear darker, dusky.
  – Will become purple-black

• **Etiology & Risk Factors**
  – Surgical technique
    • Insufficient mesentery freed up
  – Suture line under tension
  – Vasopressors
  – Hx of radiation
  – Clot

• **Treatment:** Surgery!

Image taken from: https://nursekey.com/stoma-complications/
MELANOSIS COLI

• Stoma appears “NECROTIC” however it is a result of excessive laxative use!

Image taken from: http://www.gastrolab.net/pa-385.htm
STENOSIS

• Assessment:

– Digital exam of Stoma shows a narrowing of the skin at the skin or fascia level.

– May result in an obstruction.

– May see stool come out in “ribbon” like formation.

STENOSIS

• Etiology:
  – May occur after stoma necrosis
  – Surgical Technique:
    • Inadequate excision of skin
    • Inadequate length of mesentery
  – Hx of Radiation
  – Obesity
  – Frequent dilation of stoma
    • May lead to scar tissue formation

Image taken from: https://www.kain-maerck.com/welland-stomaversorgung/
STENOSIS: TREATMENT

- Surgical Revision
- Weight loss
- May see issues with pouching appliance system, address any peristomal skin issues.
- Maintain soft stool
- Maintain adequate hydration
RETRACTION

• Assessment:
  – Stoma is flushed below skin level
  – Patient may report difficulty with pouching system
  – May be seen along with skin excoriation due to inability to maintain seal of pouching system

• Etiology:
  – Surgical technique: Mucocutaneous junction “under tension”
  – Obesity
  – Scar tissue formation from previous mucocutaneous junction separation
  – Premature removal of a loop surgical bar/device

Note: Occurs more frequently with an Ileostomy
RETRACTION

• **Treatment:**
  – Use different pouching system and accessories to obtain a seal.
    - Convex pouch to fill in depth of retraction.
    - Use of ostomy belt to make stoma protrude more into pouch.
    - Barrier ring or paste to help stoma become more at skin level.

[Image of stoma retraction]
PROLAPSE

• **Assessment:**
  - Stoma is telescoping outward
  - May appear dusky color
  - Most common site:
    • Loop stoma - distal limb

• **Etiology:**
  - Surgical technique
    • Large opening in abdominal wall
    • Inadequate fixation of bowel to abdominal wall
  - Increased abdominal pressure
  - Edematous bowel
PROLAPSE

**Treatment:**

- Reduce edema
  - Sprinkle sugar over stoma
  - Cool cloth over stoma

- Resize barrier in pouching system
  - Adjust a bigger size to accommodate for the prolapsed stoma.

- Consider use of a hernia belt for support
PARASTOMAL HERNIA

• Etiology:
  – Surgical technique:
    • Stoma is placed outside the rectus muscle
    • Fascia does not close properly around the stoma

• Risk factors:
  – Weakened abdominal musculature
  – Obesity or post op weight gain

*Note: Most common site will be the descending/sigmoid colostomy.

PARASTOMAL HERNIA

• Prevention:
  – Pre-op stoma site marking
  – Avoid lifting anything heavier than 5-10lbs at least 8 weeks post operatively
  – Avoid weight gain

*Note: Recurrence rate is high after surgical rate.

• Treatment:
  – Resize barrier to accommodate for any enlargement of the stoma.
  – Use hernia support belt: Measure and apply when hernia is reduced, ie when patient is laying down.
  – If patient has a colostomy discontinue use of irrigations
PERISTOMAL MASD: IRRITANT DERMATITIS

• **Etiology:**
  – Stool or digestive enzymes “sitting on skin”
  – Inappropriate pouching system

• **Assessment:**
  – Superficial erythema
  – Patient will report “burning pain” to their skin

Image taken from: http://psag.wocn.org/#home
PERISTOMAL MASD: IRRITANT DERMATITIS

Treatment:

– Determine cause of leaking pouching system & correct

– Use “crusting” technique to help obtain a better seal and secure pouching system.
  • Apply stoma powder
  • Seal stoma powder with a liquid skin protectant
  • Apply pouch over

– Skin will begin heal if pouching system is able to remains intact for expected 4 day wear time
CANDIDIASIS

• Assessment:
  – Macular papular rash with or without satellite lesions
  – Occurs where moisture is trapped
  – Patient may complain of itching

• Etiology:
  – Antibiotic, or steroid treatment
  – Effluent laying on skin: pouch provides perfect environment: moisture, warmth and dark.
CANDIDIASIS

• **Treatment:**
  – Make sure patient has appropriate pouching system
  
  – Begin treatment of antifungal powder
    – Caution with use of antifungal lotion because it may interfere with pouch adhesion.
  
  – May need skin protectant to seal in powder.
PYODERMA GANGRENOSUM

• **Assessment:**
  - Lesions that become indurated & ulcerated
  - Red or purple color
  - Irregular shape
  - Painful lesions
  - Highly exudative

• **Etiology:**
  - Autoimmune or inflammatory process
  - IBD
  - Leukemia
  - Multiple myeloma
  - Polycythermia vera
  - Rheumatoid arthritis

PYODERMA GANGRENOSUM

• **Treatment:**
  – Control exudate
    • Consider the following dressings:
      – Alginate
      – Hydrofera blue
    – Pouch over wound - Make sure to obtain a good seal on pouch
  – Avoid trauma to affected area
FISTULAS

- Managed similarly as an ostomy
  - Fill in any defects with paste or stoma rings
  - Protect peri-fistula skin from any effluent
  - Pouch (make sure you cut out pouch to the exact size of fistula)

REFERENCES


THANK YOU FOR YOUR TIME & ATTENTION

Questions?