Stoma Complications and Management

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DISCLOSURES
I have nothing to disclose

How to Mark a Site for a Stoma

• Sitting, Lying Down, Standing
• Lateral Edge of Rectus
• Away from creases/belt line
• http://www.ostomy.org/ostomy_info/wocn/wocn_preoperative_stoma_marking.pdf

• See patient in street clothes
• Basic Education while marking
• LOOK at the belly, how does it wrinkle, crease. Are there scars? Radiation?
• Need 2-3 inches of flat surface
• Visible to patient
• ???below belt line???
Placement Issue

Discuss options for stoma especially if above belt line:

- Stomasafe
- Stealth Belt
- Activity Belt
- Tube tops
- Suspenders

Eversion

WHY BROOKE ALL STOMAS?

The SPOUT from a Brooked stoma makes it easier to collect the effluent

More important for liquid effluent from an ileostomy than solid stool from a colostomy

But even in colostomies, eversion helps to keep appliance on

Not All Stomas are Created Equal

- Correct site critical for appliance adherence
- Eversion
- Colostomy better than Ileostomy
  - Less dehydration, skin irritation
- End stoma better than loop for permanent stomas
  - Easier to pouch
  - Less likely to prolapse or herniate
- Loop stoma much easier to reverse
Complications of Stomas

- High rate of complications
- 40-70% incidence over 15 yr. follow up
- Most occur in the first five years
- Attention to stoma formation is the most important factor in prevention

Stoma Complications

- Ischemia/Necrosis
- Retraction
- Stricture
- Skin Irritation/Applicance leakage
- Mucocutaneous separation/Abscess/fistula
- Hernias
- Prolapse
- Pyoderma Gangrenosum
- Granulomas

Stomal necrosis
Stoma Necrosis
- Partial vs Entire stoma
- reoperation to avoid perforation/peritonitis
- Partial ischemia usually managed conservatively--gentle cleansing, allows sloughing off

Stomal Stricture
- Stricture/ Hypertrophic skin changes due to irritation
- Revised locally

Stenosis/stricture
- Causes: alakaline urine, radiation tissue damage, stomal necrosis, mucocutaneous separation, ischemia

- Short term management: dilation, stool softeners, irrigation, urinary stents

Retraction
Retraction
Non-surgical management

• Convex appliance
• Belt
• paste and rings

Skin Irritation/Appliance Leakage

Excoriation/Denuding/Erosion
Eliminate the cause: refit, change more often, reduce the number of products used (keep it simple).

Water only for cleansing, use stoma powder and no-sting barrier film to protect and heal

Dermatitis Allergic vs Irritant

Look at the pattern of dermatitis-- is it at the tape border? Under the pectin portion?
Allergic

- Try to identify the product and eliminate.
- Steroid creams/sprays
- Barrier Sheets
- Referral to Dermatology
- Non-adhesive pouching systems

Irritant:
- Effluent
- Over cleansing
- Over use of skin products

Treatment:
- Simplify
- Refit
- Crust Skin
- Skin barriers

Fungal Infections

- Refit appliance
- Moisture control (cool hairdryer, pouch cover)
- Antifungal powder

Mucocutaneous Skin Separation

If superficial gentle cleansing and filling the defect with stoma powder/paste/absorbant dressing. Usually will fill in with time.
**Pyoderma vs fistula**

**Fistula**
- Underlying cause?
  - Pouch if large amount effluent
  - May need to change pouch more often

**Pyoderma Gangrenosa**
- Pain is out of proportion to visual
- Can have secondary bacterial infection
- Eliminate trauma: flat pouch, calcium alginate or other absorbant dressing.
- Steroid Cream, Steroid injections, topical tacrolimus
- Dermatology Referral

**Progression to fistula**

**Prolapse and Hernia**
Prolapse

If no ischemia or obstruction manage

Reduce stoma--lay down, gentle pressure to reduce, Cold compresses, sometimes packing prolapse in sugar to remove edema can help reduce but can be associated with fluid shifts/electrolyte imbalance.

One piece/softer appliances--avoid trauma from ring of two piece appliance.

Prolapse belt or abdominal binder

Parastomal Hernia

If obstruction, incarceration, pain, unable to pouch then surgical intervention

First try to manage--change pouching system, use of hernia support belts, prevention of progression of hernia.

Hernia and Prolapse Belts

What about eating?

- For the colostomy patient there are essentially no restrictions, but for the ileostomy patient it is important for some foods to be avoided early on to prevent an intestinal blockage
- Stringy, high fiber foods like celery, coconut, corn, coleslaw, the membranes on citrus fruits, peas, popcorn, spinach, dried fruits, nuts, pineapple, seeds, and fruit and vegetable skins
- Fish, eggs, beer, and carbonated beverages can cause excessive foul odor.
- Encourage your patients to eat at regular intervals, chew food well and drink adequate fluids. Avoid overeating and excessive weight gain.
High Output Ileostomy = Readmission

- NI Output – 500cc
- High output is greater than 1L in 24 hrs
- What to DO?
  - Fiber
  - Lomotil/Imodium/Tincture of Opium
  - Cholestryamine
  - Octreotide/Clonidine
  - TPN?Infusions

Prevention of Complications

- Location
- Attention to stoma formation
- Home health care on discharge
- Counselling/support: Life long f/u
- Wound Ostomy Continence Nurses
- Self Education: UOAA.org, C3life.com