Broaden Your Horizons in Ostomy Skin Care

Cathy Smith, ARNP, CWON, CHPN
UnityPoint Wound Healing Center

Objectives

- Review the literature pertaining to ostomy skin complications
- Describe peristomal skin complications
- Relate interventions that are effective in managing complications.

Stomal Complicatons

- Late versus early
- Stomal necrosis
- Hernia/prolapse
- Retraction/stenosis
- Obstruction
- Stomal bleeding/parastomal varices
- Stomal trauma

Husain, Caltaldo (2008); Liu, et all (2010); Salvadalena (2013; Pittman et al (2008); Pittman et all (2014)

Peristomal Skin Complications

- Mucocutaneous separation
- Pyoderma gangrenosum
- Peristomal irritant dermatitis
- Candida/tinea
- Allergic dermatitis
- Pressure ulcer
- Folliculitis

Haugen & Ratliff (2013); Ratcliff (2010); Recalla et al (2013; Ratliff (2014); Meisner (2012); Martins (2012); Neil, Inglese, Manson, Townshend (2015)

Mucocutaneous Separation

- Separation of the stomal tissue from the surrounding peristomal skin
- Treatment
  - Cut barrier larger, expose the separation.
  - Treat with absorbent material such as alginate, hydrofiber, powder, paste, barrier ring
  - Cover with skin barrier

Bates & Colwell (2014) Butler (2009)

Retraction/Stenosis

- Retraction
  - Incidence
  - treatment
- Stenosis/stricture
  - Incidence
  - Treatment

Lindholm et al (2013); Szymanski et al (2010); Liu et al (2010); Hussain, Cataldo (2008)

Pyoderma

- Several forms usually occurring on the abdomen, perineum, lower extremities
- Usually adult patients ages 20-50.
- Etiology unknown. Diagnosis made on appearance, biopsy excludes other pathology
- Lesions generally appear as full thickness ulcers, red, moist base, scattered slough, dark bluish/purple edges, pain, wound edges non adherent
- Treatment

- Gray & Catanzaro (2004); Kelly (2012); Hocevar (2009); Folkedahl, Murphy, Alexander (2002)

Irritant Dermatitis

- Moisture associated skin damage caused by exposure to effluent
  - Nature of the effluent
  - Exposure time
- Prevention
  - Ongoing assessment by WOC nurse
- Treatment

Gray et al (2013); Ratliff (2010); Goldberg et al (2010)

Candida/Tinea

- Candida, yeast like fungus, part of normal skin flora, only infects the outer layers of the epithelium of the skin.
- Tinea, dermatophyte, survive on only dead keratin.
- Treatment antifungal powder
  - Nystatin effective against candida
  - Miconazole effective against candida and tinea

Habif (2010); Ratliff, Scarano, Donovan (2005)

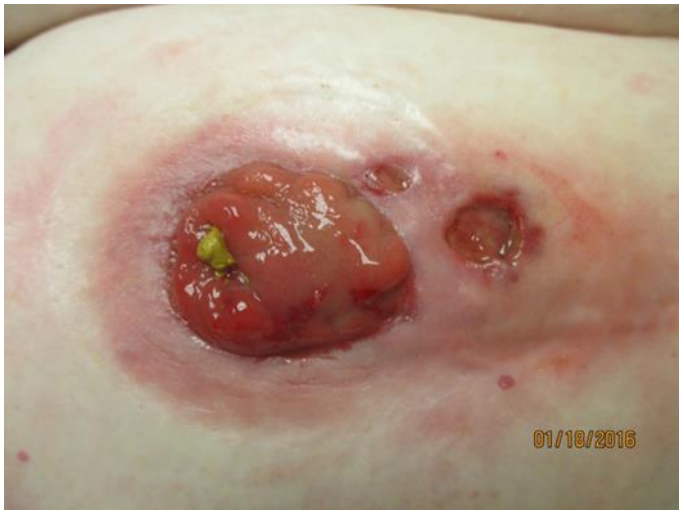
Allergic Dermititis

- Can be attributed to sensitivity to the components of the equipment, topical ointments, deodorizers, adhesives, skin cleansers.
- Remove the offending product
- Patch testing

Agarwal& Ehrlich (2010)

Pressure Ulcer

- Incidence
- Cause
- Treatment
  - Remove the pressure
  - Alginate, thin hydrocolloid/transparent film, hydrofera blue ostomy
  - Change pouching system more frequently



Hoeflok, Kittscha, Purnell (2012)

Folliculitis

- Electric clipper
- Gently remove flange
- Reduce frequency of shave. Use clean razor

Bates & Colwell (2014)

Convexity

- Indications
- Definition of convexity
- Rigid convex, “soft” convex
- Barrier rings, convex barrier rings
- Depth, profile, tension, construction
- Reevaluation, how often
- Complications
- Contraindications

Hoeflok, Kittscha, Purnell (2013); McKenzie, Ingram (2001); Bourke, Davis, Dunne et al (2007); Boyd, Thompson, Boyd-Carson, Trainor (2004).

Wear Time

- Study published 2008
  - Mean wear time 4.8 days
  - Did not differ between colostomy, ileostomy, urostomy
  - BMI
  - Age

Richbourg, Fellows, Arroyave (2008)

Quality of Life

- Systematic review of the literature
  - Overall persons with stomas report difficulty with work/social functions, sexuality/body image, stoma function
  - WOC nurses can influence quality of life
    - Pre and post op education
  - Sexuality

Obstruction

- Physical causes: hernia, stricture, stenosis, recurrent Crohn's, malignancy, volvulus
- Food blockage
  - Near the stoma
  - Due to diet
  - See next slide

EMERGENCY ROOM STAFF: ILEOSTOMY OBSTRUCTION

Symptoms: No stomal output, cramping abdominal pain, nausea and vomiting, abdominal distention, stomal edema, absent or faint bowel sounds.

1. Contact the patient's surgeon or WOCET Nurse to obtain history and request orders.
2. Pain medication should be initiated as indicated.
3. Start IV fluids (Lactated Ringer's Solution/Normal Saline) without delay.
4. Obtain flat abdominal x-ray or CT scan to rule out volvulus and determine the site/cause of the obstruction. Check for local blockage (peristomal hernia or stomal stenosis) via digital manipulation of the stoma lumen.
5. Evaluate fluid and electrolyte balance via appropriate laboratory studies.
6. If an **ileostomy lavage** is ordered, it should be performed by a surgeon or ostomy nurse using the following guidelines:

- Gently insert a lubricated, gloved finger into the lumen of the stoma. If a blockage is palpated, attempt to gently break it up with your finger.
- Attach a colostomy irrigation sleeve to the patient's two-piece pouching system. Many brands of pouching systems have Tupperware®-like flanges onto which the same size diameter irrigation sleeve can be attached. If the patient is not wearing a two-piece system, remove the one-piece system and attach a colostomy irrigation sleeve to an elastic belt and place it over the stoma.
- Working through the top of the colostomy irrigation sleeve, insert a lubricated catheter (#14–16 FR) into the lumen of the stoma until the blockage is reached. Do not force the catheter.
- **Note:** If it is possible to insert the catheter up to six inches, the blockage is likely caused by adhesions rather than a food bolus.
- Slowly instill 30–50 cc NS into the catheter using a bulb syringe. Remove the catheter and allow for returns into the irrigation sleeve. Repeat this procedure instilling 30–50 cc's at a time until the blockage is resolved. This can take 1–2 hours.

7. Once [illegible] pouch system should be applied. Because the stoma may be edematous, the opening in the pouch should be slightly larger than the stoma.

HOW TO TREAT ILEOSTOMY BLOCKAGE

Symptoms: Thin, clear liquid output with foul odor, cramping abdominal pain near the stoma, decrease in amount of or dark-colored urine, abdominal and stomal swelling.

Step One: At Home

1. Cut the opening of your pouch a little larger than normal to [illegible] the stoma may swell.
2. If there is stomal output and you are not nauseated [illegible] only consume liquids such as Coke, sports drinks, or [illegible]
3. Take a warm bath to relax the abdominal muscles.
4. Try several different body positions, such as [illegible] chest position, as it might help move the blockage forward.
5. Massage the abdomen and the area around the stoma as this might increase the pressure behind the blockage and help it to "pop out." Most food blockages occur just below the stoma.

Step Two: If you are still blocked, vomiting, or have no stomal output for several hours:

1. Call your doctor or WOCET Nurse and report what is happening and what you tried at home to alleviate the problem. Your doctor or WOCET Nurse will give you instructions, i.e., meet at the emergency room, come to the office. If you are told to go to the emergency room, the doctor or WOCET Nurse can call in orders for your care there.
2. If you cannot reach your WOCET Nurse or surgeon and there is **no output** from the stoma, go to the emergency room immediately.
3. **IMPORTANT:** TAKE THIS CARD WITH YOU TO THE EMERGENCY ROOM AND GIVE IT TO THE PHYSICIAN.
4. **IMPORTANT:** TAKE ALL OF YOUR POUCH SUPPLIES (eg., pouch, wafer, tail closure, skin barrier spray, irrigation sleeve, etc.)

01/18/2016

UOAA United Ostomy Associations of America, Inc.

United Ostomy Associations of Amer
P.O. Box
Kennebunk, ME 04
800-826-0826, www.ostomy

Ileostomy Instructions

- ILEOSTOMY INSTRUCTIONS
- 1. You should be emptying your ileostomy pouch or bag 5-6 times a day, which in a 24 hour period is about 1500mL or less per day. Your stool in the ileostomy bag should be thick like pudding or applesauce. If you are emptying your ostomy appliance more than 10 times a day or having more than 1500mL output per day, adjust your diet. Stool thickening foods include pasta, peanut butter, cheese, applesauce, breads, bananas, boiled rice, tapioca. Avoid high sugar foods as these may cause an increase in output.
- 2. Your urine should be light yellow in color and at least 5 or 6 cups a day.
- 3. Is important to watch for signs of dehydration that can happen when your body is not getting enough fluid.
- Thirst or dry mouth
- Muscle cramps
- Dark-colored urine
- Feeling weak or tired
- Feeling dizzy
- 4. You need to keep drinking fluids. Good fluids are water, broth, and electrolyte drinks such as Gatorade G2, power aid and Pedialyte. Avoid drinks with caffeine, alcohol or carbonation because these fluids may cause your body to dehydrate or have less fluid.
- Metamucil (or equivalent fiber supplement) will be the first medication to try along with a stool thickening diet. It is important to follow the instructions in #1 above. If after 12-24 hours output does not slow, begin Metamucil.
- 1. Metamucil powder, 1 teaspoon, orally in 4 ounces of liquid or mix in pudding or yogurt. Hold all fluid for 45 minutes after you take it. Take twice a day as needed. Take after breakfast and after the evening meal.
- Imodium or loperamide is the second medication to try along with Metamucil and a stool thickening diet.
- 1. Imodium 2 mg tablet, one orally 30 minutes prior to meals and bedtime. Start by taking one tablet 30 minutes prior to breakfast and evening meal and adjust as needed. Can open the capsule and sprinkle into applesauce or pudding.
- Start with 2 mg twice a day. If output does not slow down after 12-24 hours, increase to 2 mg capsules, 4 times a day. Continue to eat a stool thickening diet and taking the Metamucil after breakfast and the evening meal.

References

- Agarwal & Ehrlilch (2010). Stoma dermatitis: Prevalent but often overlooked. Dermatitis, 21(3), 138-147/
- Beitz & Colwell (2007). Stomal and Peristomal Complications. JWOCN, 41(5), 445-454.
- Bourke, Davis, Dunne et al (2007). Making sense of convexity. White paper. Hollister Inc, 2000 Hollister Drive, Libertyville, Illinois.
- Boyd, Thompson, Boyd-Carson, Trainor (2004). Use of convex appliances. Nursing Standard, 18(20) 37-38.
- Butler (2009). Early postoperative complications following ostomy surgery. JWOCN, 36(5), 513-519.
- Folkedahl, Murphy, Alexander (2002) JWOCN, 29(2), 109-114.
- Goldberg, Aukett, Carmel et al (2010). Management of the patient with a fecal ostomy: Best practice guideline for clinicians, Wound Ostomy and Continence Society, Mount Laurel, NJ.
- Gray & Catanzaro (2004). What interventions are effective for managing peristomal pyoderma gangrenosum? JWOCN, 31(5), 249-255.
- Habif (2010). Clinical Dermatology: A color guide to diagnosis and therapy. 6th edition. Elsevier inc.
- Haugen & Ratliff (2013) Tools for assessing peristomal skin complications. JWOCN, 40(2), 131-134.

References

- Hocevar (2009). Nonhealing peristomal ulcer. JWOCN, 36(6), 649-650.
- Hoeflok, Kittscha, Purnell (2013). Use of convexity in pouching. JWOCN, 40(5), 506-512.
- Hussain, Caltaldo (2008). Late stomal complications. Clinics in Colon and Rectal Surgery, 21(1), 31-40.
- Kelly (2012). Peristomal complication. JWOCN, 39(4), 425-427.
- Lindholm, Persson, Carlsson, Hallen, Fingren, Berndtsson (2013). Ostomy related complications after emergent abdominal surgery. JWOCN, 40(6), 603-610.
- Liu, et al (2010). Early and late complications among long-term colorectal cancer survivors with ostomy or anastomosis. Diseases of Colon and Rectum, 53(2), 200-212.
- Martin (2001). Assessment of stomal necrosis: the test tube. JWOCN, 28(5), 233-235.
- Martins, Tavernelli, Sansom, et al (2012). Strategies to reduce treatment costs of peristomal skin complications. British Journal of Nursing, 21(22), 1312-1315.
- McKenzie, Ingram, Dansac (2001). Invent convex in the management of flush stomas. British Journal of Nursing, 10(15), 1005-1009.
- Meisner, Lehur, Moran, et al (2012) Peristomal skin coplications are common, expensive, and difficult to manage: a population based cost modeling study, PLoS ONE, 7(5): e37813.

References

- Neil, Inglese, Manson, Townshend (2015). A cost utility Model of Care of peristomal skin complications. JWOCN, open access, 1-7.
- Pitman, Bakas, Ellett et al (2014). Psychometric evaluation of the ostomy complication severity index. JWOCN, 41(2), 147-157.
- Pittman, Rawl, Schmidt et al (2008). Demographic and clinical factors related to ostomy complications and quality of life in veterans with an ostomy. JWOCN, 35(5), 493-503.
- Ratliff (2010). Early peristomal skin complications reported by WOC nurses. JWOCN, 37(5), 505-510.
- Ratliff (2014). Factors related to ostomy leakage in the community setting. JWOCN, 41(3), 249-253.
- Recalla, English, Nazarali et al (2013). Ostomy care and management. JWOCN, 40(5), 489-500.
- Salvadalena (2013). The incidence of stoma and peristomal complications during the first 3 months after ostomy creation. Journal of Wound Ostomy Continence Nursing, 40(4), 400-406
- Szymanski, St-Cyr, Alam, Kossouf (2010). External stoma and peristomal complications following radical cystectomy and ileal conduit diversion: a systematic review. Ostomy Wound Management, 56(1), 28-35.
- United Ostomy Associations of America. http://www.ostomy.org