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 Complications

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

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

Retraction/Stenosis

- Retraction
  - Incidence
  - Treatment

- Stenosis/stricture
  - Incidence
  - Treatment

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

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 Dermatitis

- 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

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 stools output, changing abdominal pain, nausea and vomiting, abdominal distension, unusual odors, absent or foul tasting stools.

1. Contact the patient’s surgeon or WOC/ET Nurse to obtain history and ordered orders.
2. Pain medication should be included as needed.
3. Start & Fluids: (Fluid Loss) Ringer’s Solution/Normal Saline without dextrose.
4. Obtain plain abdominal x-ray or CT scan to rule out volvulus and determine the site and cause of the obstruction. Order for local blockage, gastrografin enema or stool removal via digital manipulation of the stoma lumen.
5. Evaluate fluid and electrolyte balance via appropriate laboratory studies.
6. If an Ileostomy Image is ordered, it should be performed by a surgeon or mobilization nurse using the following guidelines:
   a. Gently insert a lubricated, gloved finger into the lumen of the stoma. If a blockage is palpable, attempt to gently break it up with your finger.
   b. Attach a colostomy irrigation sleeve to the patient’s two-piece pouching system. Many brands of pouching systems have Tapered® irrigation sleeve or sleeves 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.
   c. 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.
   d. 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.
   e. Slowly instill 30-50 cc NS into the catheter using a bulb syringe. Remove the catheter and allow for return into the irrigation sleeve. Repeat this procedure, instilling 30-50 cc at a time until the blockage is resolved. This can take 1-2 hours.

7. Once the blockage has been resolved, a new pouch system should be applied. Because stomas may be edematous, the opening in the pouch should be slightly larger than the stoma.

HOW TO TREAT ILEOSTOMY BLOCKAGE

Symptoms: Foul, clear liquid output with flat odor; cramping, abdominal pain near the stoma, decrease in amount of or dark-colored stools, abdominal and stoma swelling.

Step One: At Home
1. Cut the opening of your pouch a little larger than normal to allow for the stoma to swell.
2. If there is stoma output and you are not nauseated, electrolyte deficiency, only consume liquids such as Coke, sports drinks, or fruit punch.
3. Take a warm bath to relax the abdominal muscles.
4. Try several different body positions, such as the knee-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 “pop out.” Most food blockages occur just below the stoma.

Step Two: If you are still blocked, vomiting, or have no stoma output for several hours:
1. Call your doctor or WOC/ET Nurse and report what is happening and what you did at home to alleviate the problem. Your doctor or WOC/ET Nurse will give you instructions on how to proceed. If you are told to go to the emergency room, the doctor or WOC/ET Nurse can call in orders for your care there.
2. If you cannot reach your WOC/ET 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 (pouch, water, tail closure, skin barrier spray, irrigation sleeve, etc.)
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. It 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

References

References

- United Ostomy Associations of America. http://www.ostomy.org