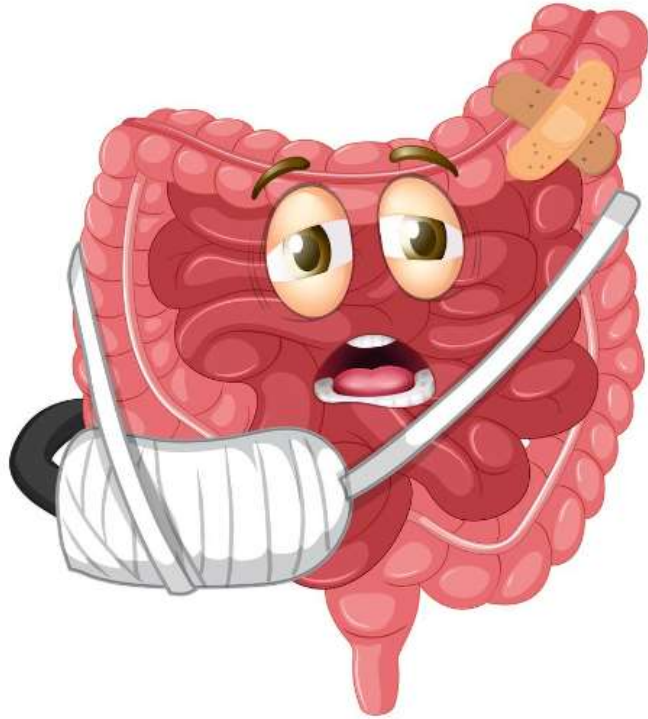


Terror at the Academy: MISERY



Outpatient Ostomy and Fistula Complications

Presented by:
Theresa Pineda RN,BSN,CWOCN and
Tammy Lichtman RN, BSN, CWON

Learning Objectives

- Identify ostomy and fistula complications
- Discuss post-acute treatment options
- Explain the importance of multidisciplinary care
- Describe supply solutions
- Investigate best practice

Peristomal Skin Health

“Skin pH is affected by moisture, sweat, sebum, and the body's anatomical site. The optimal skin pH is approximately 5.4, with a range of 4 to 7.1. Microclimate conditions exert a direct impact on the skin's barrier function.”



Peristomal Skin Health

A WOCN Society Consensus Conference

Catherine R. Ratliff ♦ Margaret Goldberg ♦ Kelly Jaszarowski ♦ Laurie McNichol ♦ Joyce Pittman ♦ Mikel Gray

ABSTRACT

The Wound, Ostomy, and Continence Nurses (WOCN) Society identified the need to define and promote peristomal skin health. A task force was appointed to complete a scoping literature review, to develop evidence-based statements to guide peristomal skin health best practices. Based on the findings of the scoping review, the Society convened a panel of experts to develop evidence- and consensus-based statements to guide care in promoting peristomal skin health. These consensus statements also underwent content validation using a different panel of clinicians having expertise in peristomal skin health. This article reports on the scoping review and subsequent 6 evidenced-based statements, along with the generation and validation of 19 consensus-based statements, to assist clinical decision-making related to promoting peristomal skin health in adults.

KEY WORDS: Colostomy, Consensus, Content validation, Evidence-based, Ileostomy, Ostomy, Peristomal skin health, Peristomal skin integrity, Scoping review, Urostomy.

INTRODUCTION

Approximately 1 million people living in the United States and Canada have an ostomy and approximately 100,000 ostomies are performed each year in the United States.¹ Ostomy literature cites that up to 80% of individuals with an ostomy will experience peristomal skin complications (PSCs).² However, there is a paucity of information related to healthy peristomal skin characteristics despite its importance for the individual with an ostomy. Peristomal skin provides the surface around the stoma to which ostomy pouching systems adhere. If peristomal skin integrity is compromised, loss of adherence of the pouch, resulting in leakage or undermining without visible leakage, is common and may progressively impair peristomal skin health. Greater emphasis should be placed on maintaining peristomal skin health to augment an overall management plan for preventing and treating PSCs.

While a significant volume of research has focused on describing the epidemiology of various ostomy complications including PSCs, little research has focused on characteristics and determinants of healthy peristomal skin.³ Studies have shown that individuals with ostomies frequently fail to perceive that they have a PSC.^{4,6} Education on how to distinguish healthy peristomal skin from unhealthy peristomal skin is critical to seek treatment earlier and minimize PSCs. The purposes of this article is to report findings from a scoping review on peristomal skin health, and summarize results of a consensus conference, which generated consensus-based statements from the scoping review.

METHODS

The Society appointed a task force to review the literature relevant to skin health and peristomal skin health. The task force comprised 5 individuals with expertise in ostomy care including PSCs (C.R., M.G., K.J., M.L., and J.P.). Task force members were responsible for reviewing the literature, generating draft consensus statements, and authoring the article. Based on the limited evidence regarding peristomal skin health, the task force completed a scoping review to identify current best practice evidence on peristomal skin health. A scoping review is a structured technique of examining the literature to identify key concepts, levels of evidence, and gaps in the evidence. The review used the method described by Levac and colleagues⁷ and refined by Colquhoun and coworkers.⁸ The primary aim was to identify: current knowledge and clinical evidence guiding the concept of peristomal skin health; intrinsic and extrinsic factors affecting peristomal skin health; and gaps in evidence, which required generation of consensus-based best practice statements. Results of the structured review were also used to generate levels of evidence underlying these statements using a 3-point ordinal scale adapted from a taxonomy for Statements for Recommendations for Treatment statements

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Peristomal
Inflammation and
Pouching Difficulty



Peristomal Inflammation and Pouching Difficulty



Inflammation Treatment Consideration

If fungus is ruled out, consider Betamethasone gel:

- Potent topical corticosteroid that penetrates without leaving a greasy layer to allow for pouching
- Reduces inflammation caused by allergic reactions or irritation
- Do not use beyond 2 weeks



Characteristics and Consensus: Convexity

Ostomy Care

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OPEN

Characteristics of Convex Skin Barriers and Clinical Application

Results of an International Consensus Panel

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ABSTRACT

Regulatory bodies do not set parameters for measuring certain ostomy product characteristics. As a result, each manufacturer has a different way of measuring specific convex skin barrier characteristics that may create confusion among clinicians when selecting a product. In order to alleviate this confusion and encourage consistency in reporting product characteristics, an international meeting of clinicians with expertise in the care of persons living with an ostomy was convened. The goal of the meeting was to define and establish consistency in convex skin barrier characteristics and their clinical application of the product based on these characteristics. Twelve nurse panelists from 11 countries reviewed, discussed, and reached consensus on a group of proposed statements designed to provide standard definitions of convex skin barrier characteristics and clinically relevant application. The group reached consensus on 5 characteristics of convex skin barriers: depth, compressibility, flexibility, slope, and tension location. These statements provide a basis for quantifying the most clinically relevant characteristics of convex skin barriers and a framework for their application in clinical practice.

KEY WORDS: Compressibility, Consensus development conference, Convexity, Depth, Flexibility, Ostomy, Skin barrier, Slope, Surgical stomas, Tension location.

INTRODUCTION

Ostomy skin barriers are available in different shapes. A flat skin barrier has a level or even adhesive surface and is ideally suited for a stoma that protrudes above a flat peristomal

skin surface that is free of creases and folds. The curvature of a convex skin barrier is designed to create a secure seal for a stoma that does not protrude above the peristomal skin plane or an ostomy surrounded by peristomal skin that has creases and folds.¹ Selecting a convex skin barrier that achieves a secure seal or good fit depends on multiple components of skin barrier construction.²

Regulatory bodies do not set parameters for measuring certain ostomy product characteristics. As a result, manufacturers have adopted different means for measuring and describing specific characteristics of convex skin barriers such as depth, slope, or compressibility. Variability in the methods force clinicians to select convex skin barriers based on subjective assessment rather than objective criteria. We assert that objective and reproducible measurements for convex skin barriers are essential when comparing the performance of convex to flat skin barriers (skin barriers that do not incorporate convexity). Therefore, the goal of this publication is to define essential characteristics of convex skin barriers in order to facilitate a more objective evaluation when selecting a convex skin barrier, encourage consistency among manufacturers when identifying characteristics of their convex skin barriers, and provide a basis for the quantitative clinical research needed to provide an evidence-based practice.

METHODS

Due to a lack of evidence to guide selection of ostomy skin barriers with convexity, we chose to base statements on consensus. The consensus process we selected provides a structured approach for constructing and achieving consensus around



Depth- measurement of the apex of the dome to the base (consider the depth of the creases and folds).



Compressibility- capacity of the dome to be flattened (easily compressible should be considered with post-op edema, firm abdomen, or the need to conform to abdominal contours).



Flexibility- how easily can the convex barrier bend (consider abdominal contours).



Tension Location- position in which the convex dome exerts pressure downward and outward (consider where additional tension needs to be placed, close to stoma or away from stoma).



Slope- the angle from the base of the barrier to the apex of the dome (consider less steep slope to and wider plateau to flatten peristomal skin).

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Convexity Consensus Statements

Primary goals: Secure a reliable seal around the stoma to avoid leakage; *predictable* wear time; and contribute to an optimal quality of life for the patient.

Safe to use regardless to when stoma was created.

Should be considered immediately post-op,

Considered if leaking, peristomal skin complications, creases or folds present, or stoma opening is level or below skin level.

Consider a belt if convexity alone does not provide a secure seal.

Follow up with an ostomy nurse specialist recommended 2 weeks post discharge following stoma creation or revision

Full assessment of the patient's ostomy needs should be conducted in each postop period stage.

If a change in pouching system is made, reassessment should be made by ostomy specialist 2-3 weeks after to assess new system outcome.

Postoperative Period:

- Immediate Postoperative Period Days 0-8
- Postoperative Period Days 9-30
- Transition Period Days 31-180

Ostomy Care

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OPEN

Use of a Convex Pouching System in the Postoperative Period

A National Consensus

Janice C. Colwell ♦ Janet Stola Davis ♦ Kristina Emodi ♦ Jane Fellows ♦ Mary Mahoney ♦ Bethany McDiade ♦
Sima Porten ♦ Elizabeth Raskin ♦ Terran Sims ♦ Holly Norman ♦ Matthew T. Kelly ♦ Mikel Gray

ABSTRACT

Convex pouching systems have been available for ostomy patients for decades; however, controversy remains over the use of convexity in the postoperative period. A group of 10 nurses and physicians with expertise caring for patients with an ostomy completed a scoping review identifying research-based evidence and gaps in our knowledge of the safety and effectiveness related to the use of a convex pouching system following ostomy surgery. Results of this scoping review demonstrated the need for a structured consensus to define best practices when selecting a pouching system that provides a secure and reliable seal around the stoma, avoids undermining and leakage of effluent from the pouching system, and contributes to optimal health-related quality of life for patients following ostomy surgery. The expert panel reached consensus on 11 statements for the use of convex products immediately after surgery and throughout the first 6 months after stoma creation, as well as describing goals in choosing the best pouching system for the patient with an ostomy.
KEY WORDS: Colostomy, Convex pouching system, Convexity, Ileostomy, Mucocutaneous junction, Mucocutaneous separation, Ostomy, Peristomal skin complications, Postoperative, Urostomy

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INTRODUCTION

Approximately 1 million people in the United States live with an ostomy, and around 100,000 new ostomies are created each year in the United States.¹ The management of an ostomy includes the use of a pouching system to collect stoma effluent. The most basic goal of a pouching system is to provide reliable wear time from the time the system is applied to a planned removal time in a manner that maintains intact and healthy peristomal skin.^{2,3} A primary cause of ostomy-related complications is pouch leakage, erosion of the faceplate allowing urinary or fecal effluent to come into contact with the peristomal skin. Up to 80% of patients with an ostomy will experience peristomal skin complications.^{4,5} Peristomal skin injury is loss of the epidermis and in some cases the dermis underneath the adhesive borders of the pouching system. Multiple peristomal skin complications have been identified including peristomal moisture-associated skin damage (a form of irritant contact dermatitis), allergic contact dermatitis, medical adhesive-related skin injuries, and pressure injuries.⁶⁻¹⁰ The need for ongoing use of a pouching system creates challenges for managing peristomal skin damage. This challenge is particularly apparent when attempting to maintain an effective skin seal in the presence of injured, moist peristomal skin.¹¹ Selection of an effective pouching system that conforms around the stoma and to the peristomal body profile is essential when managing peristomal skin complications.

The adhesive barrier of an ostomy pouching system is available in multiple sizes and shapes. The opening (aperture) of the adhesive faceplate should match the size and shape of the stoma, and the contours of the faceplate should accommodate the

US Study to Validate Convexity Use in the Post-op Period

- “A survey of 332 experienced ostomy care clinicians’ use of convex pouching systems during the postoperative periods found that a majority of clinicians practicing in the United States use convexity during the immediate postoperative and postoperative periods following ostomy surgery. Study findings support current best practice guidelines.”



OPEN

Survey Results on Use of a Convex Pouching System in the Postoperative Period

Janet Stola-Davis • Janice C. Colwell • Kristina Emodi • Jane Fellows • Mary Mahoney • Bethany McDade • Sima P. Porter • Elizabeth R. Raskin • Holly S. Norman • Matthew T. Kelly • Terran Sims

ABSTRACT

PURPOSE: The purpose of this study was to validate time frames for postoperative care following stoma surgery and to determine participants' current practices with convex pouching systems during the postoperative period.

DESIGN: A cross-sectional survey.

SUBJECTS AND SETTING: The sample comprised 332 ostomy care specialists practicing in the United States. Most (n = 220; 66%) had more than 10 years' experience caring for patients with ostomies, 82% (n = 272) were certified WOC or ostomy care nurses (CWOON and COON), and 7% (n = 23) were board-certified colorectal surgeons.

METHODS: A 23-item online questionnaire was created for purposes of the study. Items in the questionnaire queried professional background and experience caring for patients with an ostomy. A single item was used to identify postoperative care periods following ostomy surgery. Additional items queried current practice patterns related to use of convex pouching systems and the timing of their use. Data were collected from January 18 to February 8, 2021.

RESULTS: Most respondents (n = 270; 80%) agreed with the following postoperative periods after ostomy surgery: immediate postoperative period (days 0-8); postoperative period (days 9-30); and transition phase (days 31-180). Most respondents (n = 274; 85%) indicated they would use a convex pouching system when clinically appropriate during the first 30 days following ostomy surgery and 79% (n = 228) indicated using a convex pouching system regardless of when the surgery was performed. Less than 1% (n = 2) indicated never using convexity within the first 30 days following stoma surgery, and only 2% (n = 8) indicated avoidance of convexity pouching systems in the immediate postoperative period.

CONCLUSIONS: Findings indicate that use of convexity during the postoperative period is prevalent to provide a secure seal and predictable wear time.

KEY WORDS: Colostomy, Convex pouching system, Convexity, Ileostomy, Mucocutaneous junction, Ostomy, Peristomal skin complications, Postoperative.

INTRODUCTION

Evidence concerning the use of convex pouching systems for management of the patient with a stoma during the postoperative period is lacking.^{1,2} Further, controversy exists concerning the frequency and severity of potential complications associated with the use of a convex pouching system during the postoperative period, particularly mucocutaneous separation. Limited evidence suggests that variability in

clinical care delivery negatively impacts patient outcomes^{1,2} and health care system costs.^{3,4} Best practice guidelines consistently recognize that a secure seal around the stoma is required to minimize leakage that is associated with peristomal skin complications and diminished health-related quality of life.^{4,5}

As convex pouching systems are used to provide a secure seal for the appropriate clinical presentation, guidance on the use of convexity would benefit clinicians. Convexity assists in

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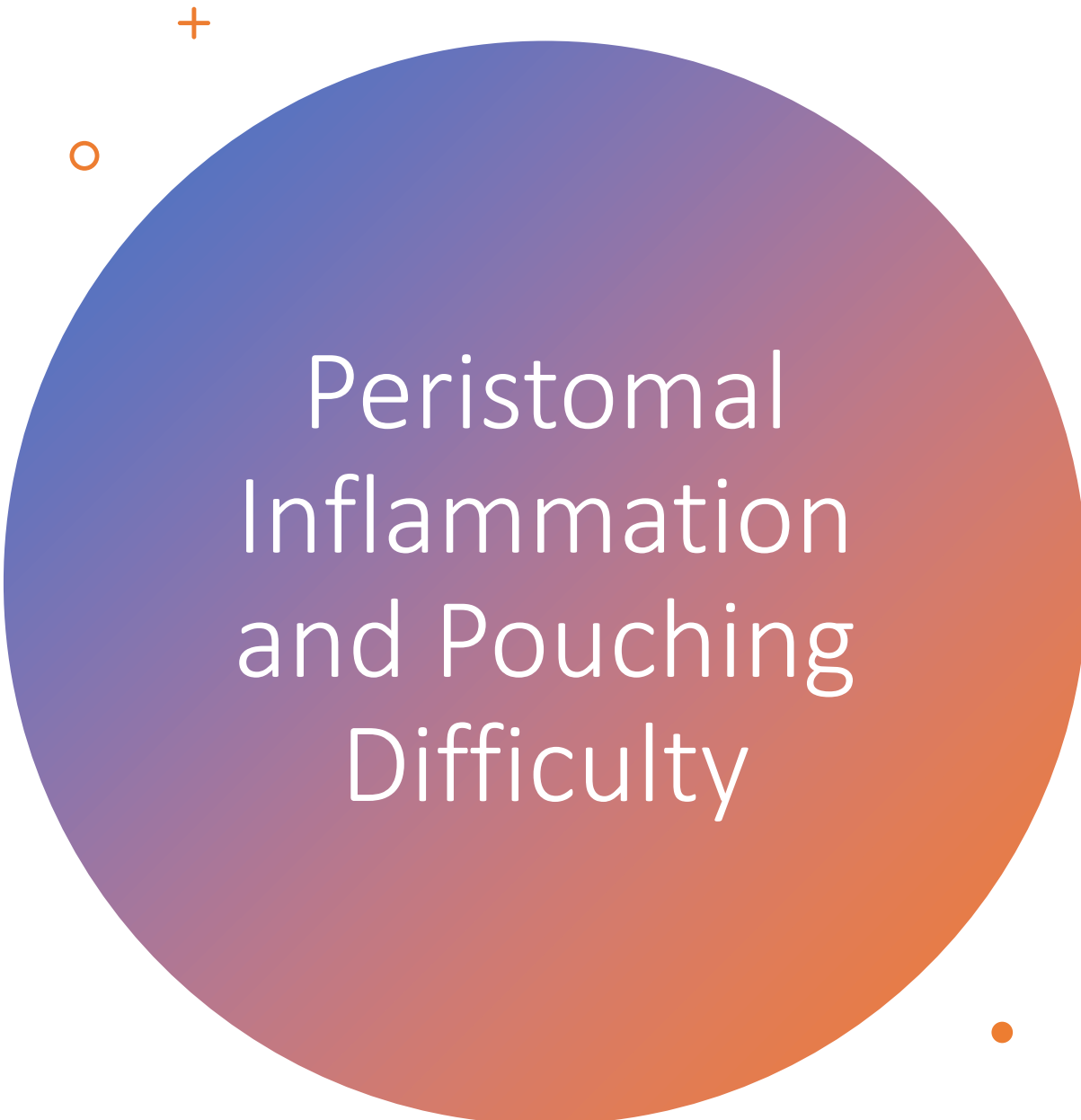
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Peristomal Inflammation and Pouching Difficulty

Flexible convexity, soft-deep depending on degree of belly softness

Treat inflammatory skin with topical steroid and or stoma powder crusting.
Treat fungal rash with antifungal powder.

Wet weeping needs to be dry for optimum pouch adherence

Brick and mortar layering of stoma dough and cohesive seal

Off set the umbilicus and use a belt to stabilize barrier and stoma

Peristomal Skin Damage/ Improper Sizing

Patient history: Crohn's disease of both small and large intestine with abscess. Ileocecal resections and loop ileostomy. Referral to Outpatient Ostomy Clinic for peristomal skin complications.

- **Patient found cutting barrier too large. (Too often, patients do not adjust template size to accommodate shrinking stoma.)**

Treatment:

- **Educate on measuring stoma and proper template**
- **Soft Convexity**
- **Crusting with stoma powder**
- **Cohesive seal**



Improper Sizing

**Assess the stoma,
measure the size and
shape**

**1st 6 weeks stoma is
maturing**

**Look at the back of the
barrier. This will give
you clues as to where
the leakage is
occurring.**

**Use filler (barrier ring,
paste, dough) in
problem-creased areas**

**Educate when stoma
changes size: weight
gain, weight loss**

**Circumferential stool
undermining, assess
and resize**

Pseudo Verrucous Lesions with Parastomal Hernia

- Resizing of wafer, shallow precut convexity
- Silver nitrate
- Antimicrobial ring with gentian violet and methylene blue for compression of lesions and dry base for pouching surface
- Hernia support belt



Pseudo Verrucous Lesions

May 2023-Aug 2023

- Patient had stoma since 1989, never saw ostomy nurse, had been cutting barrier $1\frac{3}{4}$ ", stoma measures $7/8$ "
- Os @ 6 pm skin level
- Requires suture ligation due to stoma bleeding. If there is no improvement, consider a biopsy.



Mistaken Loop Limb/ Not Wound

Patient history:

- Peristomal adhesive stripping. Staff pouching on top of the proximal limb of loop stoma (staff thought it was a wound, according to the patient)
- Treatment:
 - Protect blisters with silicone foam dressing or non-adherent antimicrobial foam or gentian violet/methylene blue and cover with a hydrocolloid sheet
 - Cut barrier to accommodate both limbs of loop stoma
 - Barrier ring
 - Soft convexity
 - Consider belt
 - Educate on atraumatic removal of the appliance



Pyoderma



Crushed Corticosteroid Tablets in Peristomal Pyoderma Gangrenosum

A Case Report

Martina Burlando • Andrea Paravisi • Giorgia Bodini • Emanuele Cozzani • Aurora Parodi

ABSTRACT

BACKGROUND: Peristomal pyoderma gangrenosum (PPG) is a variant of pyoderma gangrenosum (PG). It results from a pathergy response to trauma from effluent from the ostomy or secondary to trauma caused by removal of the ostomy appliance adhesive in contact with the skin. Currently, no evidence-based guidelines for the management of PPG exist. This case study reports a dramatic response to crushed corticosteroid tablets in a patient who proved refractory to first- and second-line treatments of her PPG and several surgeries.

CASE: Ms T, was a 39-year-old woman with Crohn's disease who underwent several ileostomies, developed PPG, and failed treatment with adalimumab. Her PPG was successfully treated topically with crushed prednisone tablets.

CONCLUSION: We found that crushed corticosteroid tablets were an effective treatment of PPG, due to the ability to reduce pain and allow adhesion of the colostomy appliance.

KEY WORDS: Adalimumab, Crushed corticosteroid tablets, Peristomal pyoderma gangrenosum, PPG treatment, Pyoderma gangrenosum.

INTRODUCTION

Pyoderma gangrenosum (PG) is a rare, debilitating, painful, inflammatory, neutrophilic disorder with variable presentations and courses.^{1,2} It is associated with an underlying disease in up to 75% of cases; the most frequent are inflammatory bowel disease (IBD), inflammatory arthritis, and hematological disorders. Due to the lack of definitive laboratory or histopathological diagnostic criteria, PG is considered a "diagnosis of exclusion" and we have observed that it is frequently misdiagnosed.

There are several clinical variants of PG, including classic, bullous, pustular, vegetative, drug-induced, postsurgical, and peristomal.¹ Peristomal pyoderma gangrenosum (PPG) was first described by Baker and colleagues in 1973; specifically, they described a pathergy response to trauma from feces that caused skin irritation, or trauma to the skin caused by the removal of the adhesive on the ostomy appliance.³ It is most

frequently seen in patients with underlying IBD.⁴ Afifi and associates⁵ reported that PPG was twice as common in patients with Crohn's disease compared to those with ulcerative colitis. Peristomal pyoderma gangrenosum is easier to diagnose than PG, but like PG, it is particularly challenging to treat because effective management requires local or systemic immunosuppression combined with ostomy-compatible wound care.^{6,7}

CASE

Ms T, was a 39-year-old woman who was diagnosed with Crohn's disease in 2009; she was treated with adalimumab (Humira; Abbvie Inc, North Chicago, Illinois) 1 injection every 2 weeks. Her medical history included rheumatoid arthritis, celiac disease, and anxiety. Her body mass index was 21.3 (within healthy weight range).

Due to a worsening of Crohn's disease in 2018, Ms T, underwent a subtotal colectomy and an ileostomy was positioned in her right abdomen. A few days later after discharge, a painful ulceration with irregular, violaceous, undermined borders surrounded by an erythematous halo appeared around her ileostomy. Peristomal pyoderma gangrenosum was diagnosed based on her clinical presentation and skin biopsy, which revealed diffuse infiltration of neutrophils in the dermis and epidermis, acanthosis and hyperkeratosis. Bacterial, viral, and fungal cultures were negative; she was treated with prednisone 25 mg twice a day for 10 days. Ms T, developed a hypertensive reaction to the prednisone, and her treatment was changed to cyclosporine (Sandimmun neoral; Novartis s.p.a., Basel, Switzerland) 200 mg per day. Her lesion was completely resolved within a few weeks. Cyclosporine was maintained at a dosage of 200 mg per day for 1 month and then reduced gradually to 50 mg every 2 weeks, until it was discontinued 2 months later.

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Treatment:

- Topical treatment options: Crushed corticosteroid tablets, highly potent corticosteroid (betamethasone or clobetasol), tacrolimus
- Resizing the barrier and placed in a soft convexity barrier
- Cover with gentian violet blue ring and then secured with a hydrocolloid strip
- Adjunctive systemic therapy: Oral steroid, broad-spectrum antibiotic
- Atraumatic barrier removal due to pathergy response of PG

Pyoderma



<https://www.Pyoderma gangrenosum: Treatment and prognosis - UpToDate>

Pyoderma/ Parastomal Hernia



Pyoderma/ Parastomal Hernia



Pyoderma/ Parastomal Hernia



Parastomal Hernia with PG/Fistula/Abscess

- **Additional interventions:**
- **Promote core muscle exercise program**
- **Support garments**
- **Diet to prevent acute/chronic constipation and diarrhea**
- **Flexible pouching options**



Pyoderma Parastomal Hernia/Fistula Abscess I+D

1 piece op pouch with window

Transformative wound powder and moist packing gauze

Placed thin layer of cohesive seal around opening and secured pouch with hydrocolloid strip

Opening must be large enough to accommodate fistula

Hernia support belt

Atraumatic removal of barrier



Peristomal Hernia with Skin Breakdown

- **PMH: 84 years old**
- **Colostomy x 4 years**
- **Seen in the Outpatient Wound Care Clinic for treatment and moved out of area. Referred to Outpatient Ostomy clinic.**
- **Peristomal Hernia measures 72 in abdominal girth**
- **Pseudo verrucous lesions around stoma**
- **Partial/Full thickness lesions peristomal skin**



WOC Recommendations

- **Culture**
- **Cleanse with Hypochlorous Acid solution**
- **Protective barrier cream covered with Hydrofiber and Brava**
- **2 ½ inch drainable flat 1 piece pouch**
- **Change 3 x a week**
- **Lidocaine for pain control**



Results after 14 days

- Patient presented to clinic with:
 - Increased shortness of breath
 - Increased lower extremity edema
 - Increased drainage
 - Required supportive O2
- Patient hospitalized with Exacerbation of CHF Kidney failure

Peristomal Abscess Secondary Stomal Stenosis

- PMH Rectal Cancer
- Incision and Drainage wound
- Lives alone
- Currently receiving Chemo
- Wears flat 1 piece closed-end pouch
- Soft abdomen with creases



3 months



Healed @ 4
months

Care of the Morbidly Obese Patient

- Obesity should be considered a risk factor that can influence poor outcomes in patients who has undergone abdominal surgical procedures
- Stoma Site Selection is a critical factor that contributes significantly to a positive outcome in an obese patient

Ostomy Care

Preoperative Stoma Site Marking Decreases Stoma and Peristomal Complications
A Meta-analysis

Mai-Yu Hsu • Jui-Ping Lin • Hsiao-Hsi Hsu • Hsing-Ling Lai • Yu-Lin Wu

ABSTRACT
PURPOSE: We systematically reviewed the literature in order to determine whether evidence indicated that preoperative stoma site marking reduces the occurrence of postoperative stoma and peristomal complications.
DESIGN: Systematic review with meta-analysis of pooled findings.
SUBJECTS/SETTING: We systematically reviewed electronic databases including PubMed, MEDLINE, CINAHL, Cochrane Library for English language articles, along with the AetL Library and Wanfang Data for Chinese articles for evidence related to the effects of stoma site marking on stoma and peristomal complications. We sought articles published from their inception to January 31, 2018.
METHODS: Ten studies that included 2100 participants, each comparing 2 groups of patients who did and did not undergo preoperative stoma site marking, were retrieved and analyzed.
RESULTS: In patients who underwent stoma site marking, the marking was associated with reduced stoma and peristomal complications in all stoma types (odds ratio [OR] = 0.52; 95% CI, 0.42-0.64; $P < .001$). Patients who underwent stoma and had local ostomies experienced fewer complications (OR = 0.34; 95% CI, 0.25-0.47; $P < .001$) than patients with unmarked stomas. In contrast, patients with unostomies did not experience fewer complications when compared to those with unmarked ostomies (OR = 0.631; 95% CI, 0.25-1.21; $P = .133$). Patients with local ostomies who had fewer hernias and peristomal skin complications (ORs = 0.25 and 0.50; 95% CIs, 0.09-0.71 and 0.20-0.44, respectively; both $P < .001$). The results revealed that stoma site marking was associated with reduced early and late stoma and peristomal complications (ORs = 0.75 and 0.36; 95% CIs, 0.61-0.94 and 0.32-0.40; $P = .010$ and $P < .001$, respectively).
CONCLUSIONS: Preoperative stoma site marking is associated with a reduced occurrence of stoma and peristomal complications and should be considered as a standard of preoperative care.
KEY WORDS: Complications, Early and late complications, Ostomy, Stoma, Stoma and peristomal complications, Stoma site marking.

INTRODUCTIONS
The reported incidence rates of stoma and peristomal complications (SPCs) vary from 12% to 72%.¹ Stoma and peristomal complications are considered quality indicators as they can lead to physical and emotional health problems, reduced health-related quality of life, increased health care costs, prolonged hospitalization, and increased morbidity.^{2,3} Tanaka and colleagues⁴ reported that peristomal skin complications were associated with economic burden: patients with SPCs have higher medical costs and longer hospitalization durations (11 days) than those without peristomal skin complications (6.8 days). Thus, interventions to prevent SPCs and negative outcomes for patients with stomas are crucial.
Stoma and peristomal complications may be classified as early and late according to the time of occurrence after surgery: early complications are defined as occurring within 30 days of surgery and late complications occur after this initial postoperative recovery period.^{2,4} The incidence of early complications such as mucocutaneous separation, stoma retraction, necrosis, and peristomal skin irritation occurred within 30 days surgery is 28.4% to 39.6%.^{5,6} Data from a survey of patients conducted 2 months after surgery showed the incidence of late SPCs such as mechanical injury, irritant dermatitis, pseudoverruca lesions, infection, and allergic responses is 6% to 47%.^{11,12}
Colwell and Beta¹³ summarized and proposed definitions for 18 SPCs. Stoma complication defined were prolapse, necrosis, mucocutaneous separation, irritation, stenosis, fistula, and trauma.¹⁴ Peristomal complications (PSCs) included

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Morbid Obesity/Stomal Stenosis/ Dehisced Abdominal Wound



Morbid obesity/stomal stenosis/
dehisced abdominal wound



Morbid obesity/stomal stenosis/
dehisced abdominal wound



Morbid Obesity/ Stomal Stenosis

Treatment:

- Stoma powder crusting
- 1-piece soft flexible convexity with ½ pie shaped cohesive seals @ 3 and 9 o'clock and then a full 4 in barrier ring around the barrier opening.
- Hydrocolloid barrier extenders and belt to secure pouch
- Patient with commercial insurance and once supply chain established, patient received supplies for q 2- day change
- Atraumatic pouch change

Psychological impact:

- Baker acted after discharge because she was so upset over issue with supplies



Morbid Obesity, Stoma Stenosis, and Stoma Revision: Colostomy to an Ileostomy

Midline abdominal wound and colostomy takedown site care:

- NPWT was not an option due to concerns about fistula formation.
- Mother performed weekly wound care utilizing transformative powder dressing, filled negative space with moist packing, and covered with a dry dressing
- Alternative options for wound care:
 - Methylene Blue/Gentian violet foam
 - Antimicrobial Alginate with collagen
 - Cadexemer Iodine gel
- Peristomal skin treatment:
 - Topical steroid gel to peristomal skin
 - Crusting
- Ostomy care 1-piece soft convexity

High Output Ileostomy

- **During hospital stay: 2-piece soft convex, high output pouch connected to a bedside drainage bag**
- **Discharged to an LTAC and placed in a 2-piece flat drainable, no bedside drain bag**
- **Discharged to home with HHC, 2-piece flat as per orders from LTAC**

This recipe = Need for Outpatient Clinic Evaluation

The patient lives alone with limited CG



Digital Instructions for HHC

- Remove old pouch and cleanse skin with warm water. Pat dry
- Crust areas of denuded skin with stoma powder
- Place Ostomy paste in creases and using a brick-and-mortar technique apply a layer of dough and cover with Cohesive seal
- Cut opening of barrier and place a cohesive ring around opening.

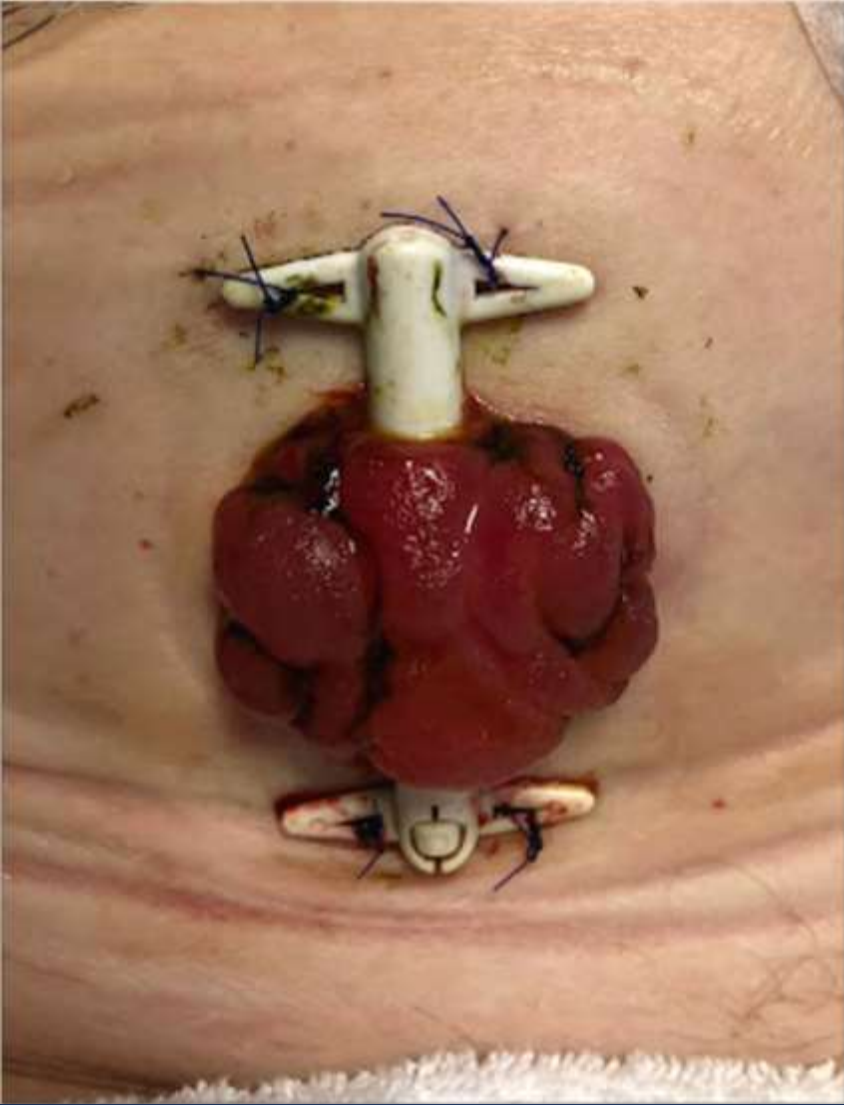




Pouching of High Output Ileostomy

Place the pouch with attached barrier over stoma and seal edges with barrier extender

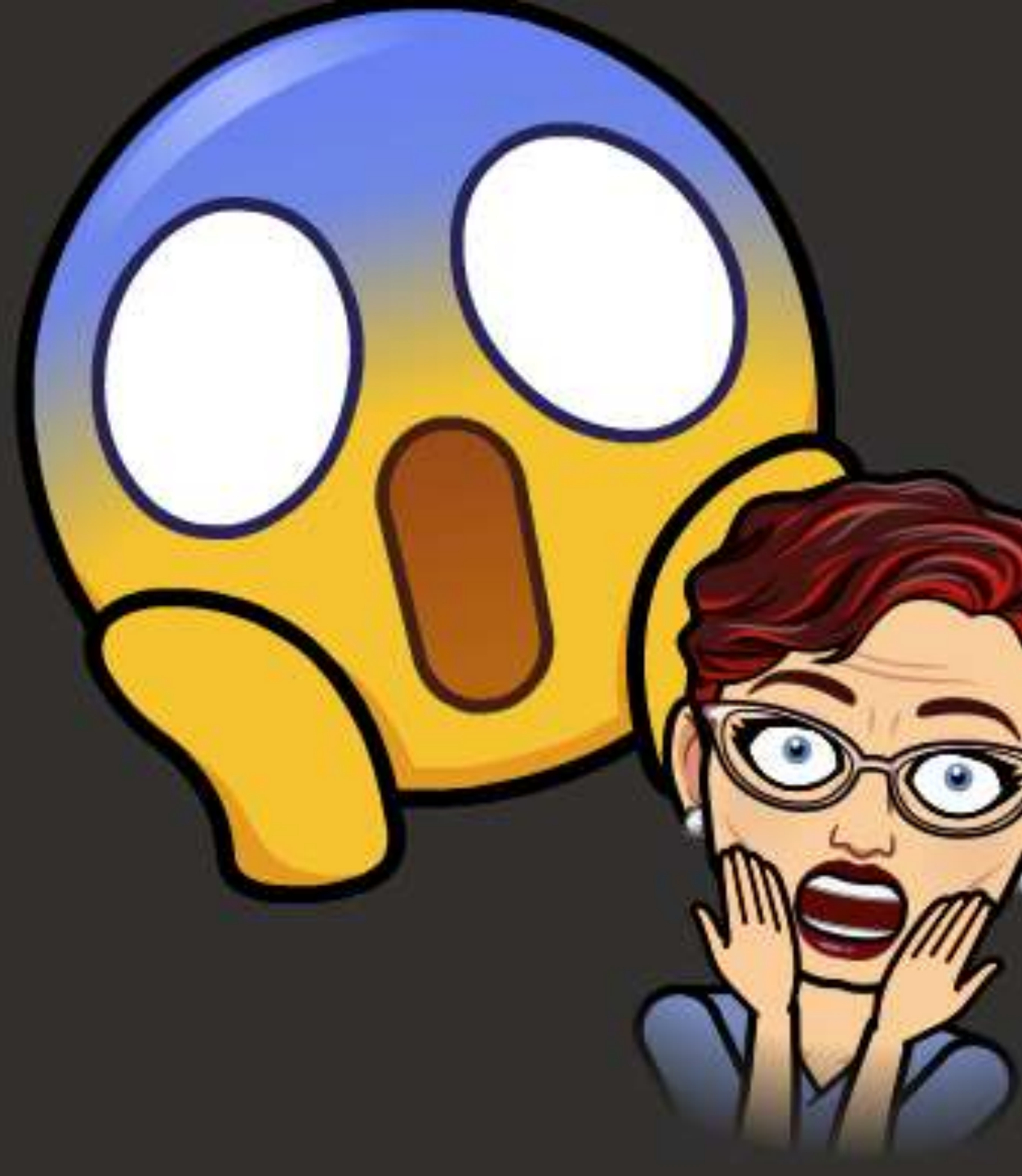




Stoma Hardware

Stoma Hardware

- Measure and/or trace pattern of irregular shape
- Accommodate the hardware if able
- Seal with cohesive ring for protection
- Patient needs to be active participant and overcome fear of touching stoma
- Collaborate with surgeon and discuss pros and cons of leaving support rod in
- Discuss continual leakage vs quality of life



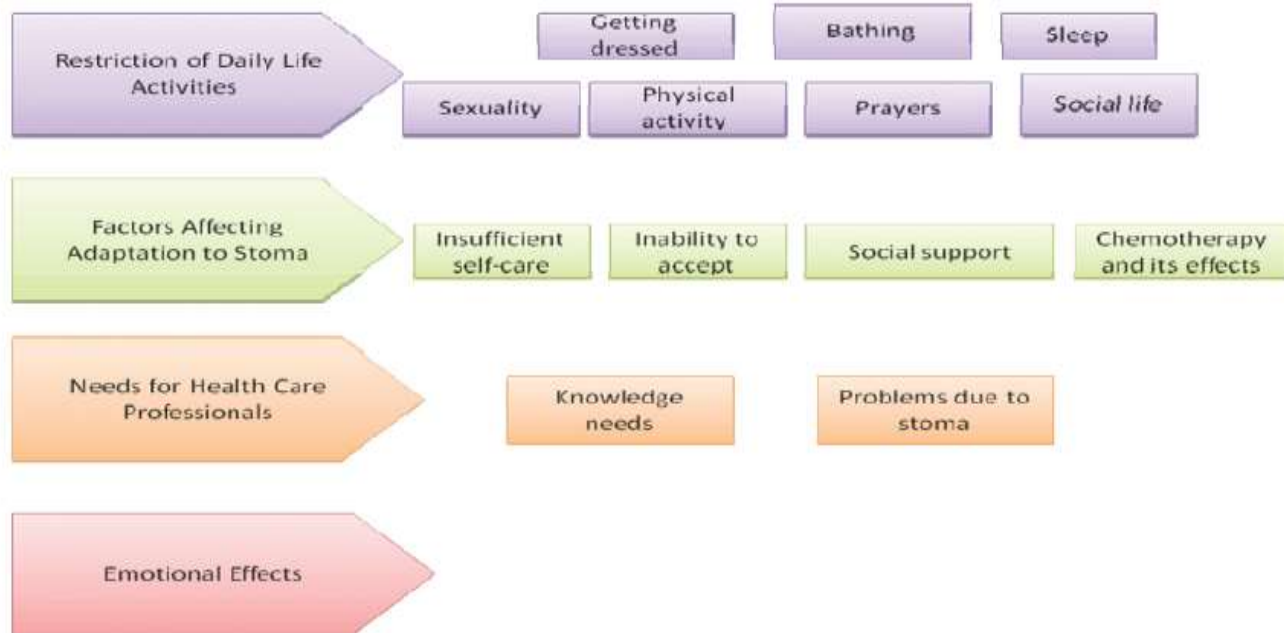


A Successful Discharge Plan

- Coordinated discharge with support of Outpatient Ostomy clinic, surgeon, Home Health Care
- Patient has supportive wife and follows care plan
- IV AB and Fluid hydration through HHC support
- Outpatient Infusion support (maintenance of PICC) line once HHC discharged
- Supplies through insurance(commercial) 7 Day Pouch Wear time



Additional Barriers Transitioning Home with a New Ostomy



Perceived Barriers and Home Care Needs When Adapting to a Fecal Ostomy

A Phenomenological Study

Burcu Cangir • Zuhai Bahar

ABSTRACT

PURPOSE: The aim of this study was to determine perceived barriers to adaptation to life with a fecal ostomy based on the Health Belief Model and to reveal home care needs related to these perceptions.
DESIGN: Phenomenological study.
SUBJECTS AND SETTING: Twelve participants undergoing ileostomy or colostomy within 3 months of data collection participated in the study. The participants were recruited from Stomatherapy Outpatient Clinic of Dokuz Eylül University Hospital. Their mean age was 54.41 ± 19.14 years (mean ± SD). Eight (67%) underwent ostomy surgery 2 to 3 months prior to study participation; 9 (75%) underwent ostomy surgery for the treatment of colorectal cancer; 5 (42%) had a temporary stoma, and 8 also received chemotherapy for the management of an underlying malignancy.
METHODS: A semistructured interview form was used to collect data, and obtained data were analyzed with inductive content analysis. The questions were based on the Health Belief Model and were directed at identifying challenges to adaptation to life at home and home care needs in patients with stomas.
RESULTS: Inductive content analysis identified 4 main themes: "restriction of daily life activities"; "factors affecting adaptation to stoma"; "need for health professionals"; and "emotional effects." The theme, need for health professionals, was expressed by the highest number of the participants. The respondents explained that services from ostomy nurse specialists should begin in the hospital and continue into the home. Participants suggested that ostomy nurses are needed to improve self-care skills via telephone contact and home visits. They also expressed the need for nursing interventions for the management of adverse effects associated with chemotherapy.
CONCLUSIONS: Individuals experience physical, mental, and social barriers when adapting to live with a new stoma and when receiving chemotherapy for underlying cancer. Additional services from ostomy nurses are needed to aid patients when adapting to these challenges.
KEY WORDS: Barriers to stoma management, Health Belief Model, Home care, Qualitative research, Stoma.

INTRODUCTION

Colostomy and ileostomy are frequently created for management of various diseases including colorectal cancer. Perianal skin damage, stomal stenosis, parastomal hernia, retractions, and mucocutaneous dehiscence are frequently encountered complications.^{1,2,3,4} Multiple studies have shown that the creation of an ostomy negatively influences health-related quality of life, body image, sexuality, and psychosocial factors such as coping and adapting to the new stoma.^{5,6,7,8,9,10,11,12} These studies also show that the psychosocial effects of a stoma are influenced by culture.

Few studies have focused on experiences of Turkish persons with new stomas, and we identified no studies that specifically focus on home care needs of these individuals.^{13,14} The aim of this study was to determine perceived challenges to adapting to a new fecal ostomy and identifying home care needs of these individuals.

METHODS

A phenomenological design guided data collection and analysis. In-depth interviews were conducted from February 2014 to August 2014. We recruited subjects scheduled to undergo creation of a fecal ostomy (colostomy or ileostomy) within 5 months of data collection. Inclusion criteria were age 18 years or older, residing in Izmir, Turkey, and able to read, write, and respond to questions. Closure of the stoma during data collection was an exclusion criterion. Research procedures were reviewed and approved by the noninvasive research ethics committee of Dokuz Eylül University (approval number 2012/12-06 and protocol number 599-GDA). Study goals and procedures were provided to all participants who provided written informed consent before data collection began (Table 1).

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Benefits of WOC Specialist

Preoperative Ostomy Education contributes to shorter hospital stays and quicker mastery of care

Patients receiving preoperative stoma marking had lower rates of anxiety and improved health related quality of life indicators

Enhances acceptance of a new body image

Promotes self-care

Promotes self-management of complications

How to Set Patient Up for a Successful Discharge

Preop Teaching

Preop Stoma Marking

3-4 Purposeful post op visits where patient or C/G interact had have hands on experience'

Assess where patient lives, where the bathroom is, does bathroom have countertop and /or mirror. What side of bed patient sleeps on. Does patient even sleep in a bed?

Is patient employed, disabled, is there an available CG?

Is patient ambulatory, Wheelchair bound?

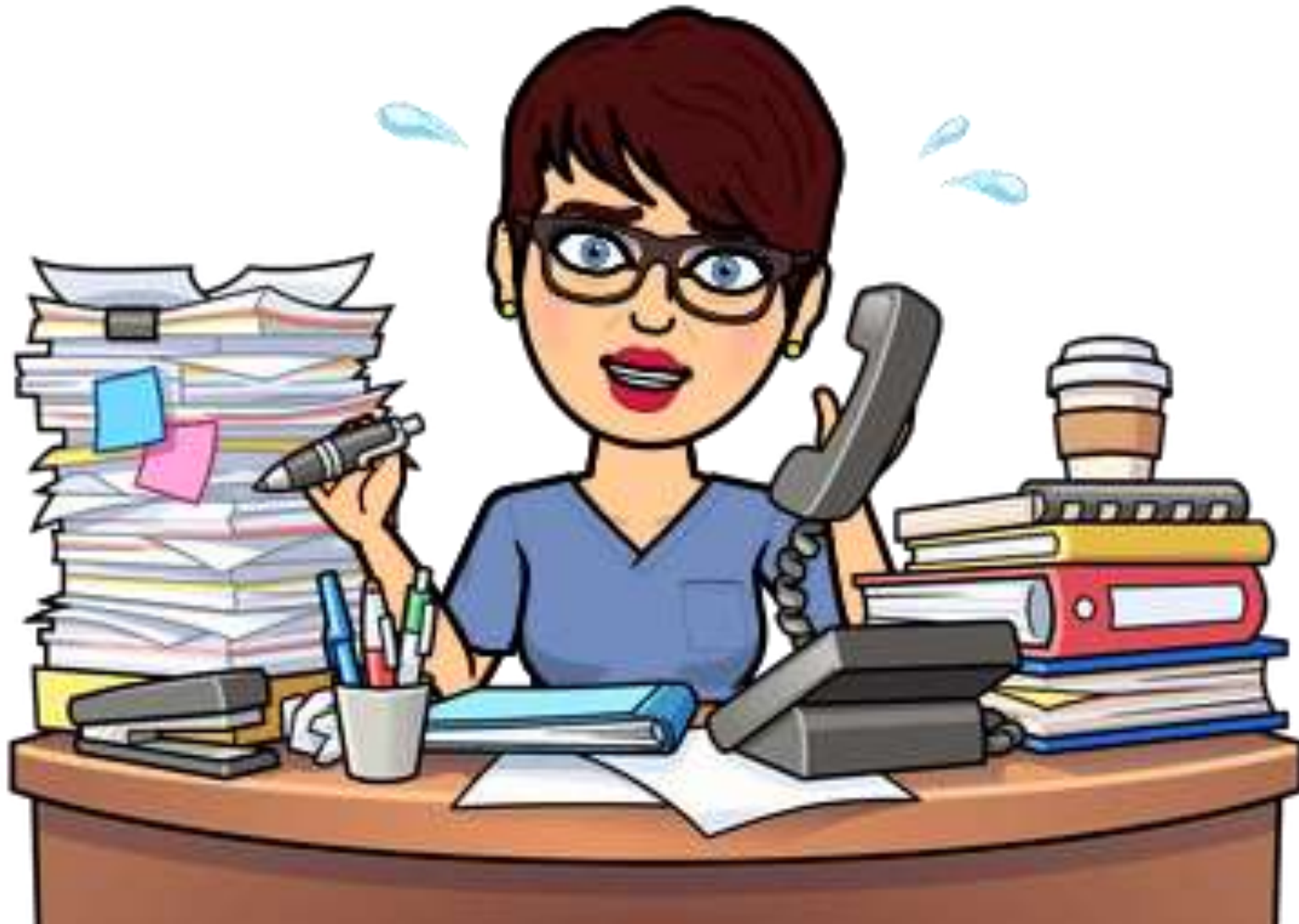
Successful Transition

- Large pendulous breast or abdomen. Can patient visualize stoma?
- Does patient know "Survivor skills"? (What to do with a leaking ostomy @ 0300 am or at Home Depot)
- Refer to Industry Sample Programs Recommend a 1-piece soft convex barrier to be sent to home
- What constitutes an emergency
- Telephone number of Md, Surgeon, Ostomy Clinic, Who is the HHC company.
- Send home with supplies from hospital

The Baton Pass

- Collaboration between Home Health Care and Ostomy Clinic
- Collaboration and Communication with Surgeon, patient, and WOC nurse.



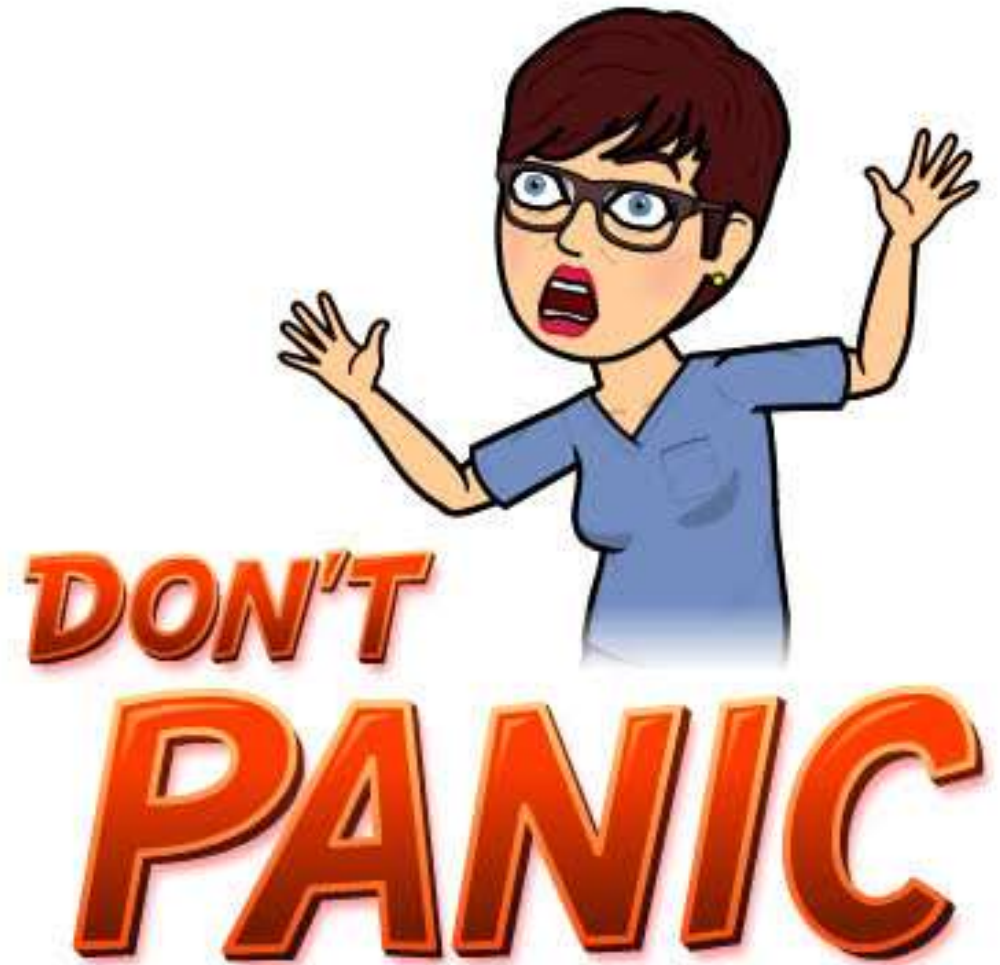


Ordering Supplies

- National Suppliers with contracts to major insurance plans, Medicare and Medicaid
- Accept Assignment of Benefits and is a participating provider
- Medicare pays 80% , co pays, supplemental insurance

Submitting 1st Order

- Order to include all important information and specific supplies needed
- Submit order, verbally, fax, electronic
- Manufacture Support Program can assist
- Order for 30 days initially



If Home Health Care Ordered

If patient has **Medicare HHA** must provide all ostomy and ostomy related supplies

Patient with **Commercial** and **Managed Care** it is responsibility of patient to order and obtain supplies



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