



# The Ostomy Journey

## Challenges in Ostomy Care

Jane Nichols, MSN, CNS, CWON



# Objectives

- ▶ **Identify the nurse's role in care of ostomates throughout their surgical experience:**
  - ▶ **Pre-operative counseling and marking**
  - ▶ **Immediate post-operative period**
  - ▶ **Long term adjustment**

# Who Has an Ostomy?










# Statistics

- ▶ **725,000 to 1 million Ostomy Patients in US**
- ▶ **100,000 new ostomy surgical procedures occur annually**
- ▶ **Globally 1.65 million new cases and almost 835,00 deaths in 2015**
  
- ▶ **Study of 11 countries found 60% older than 60 years**
- ▶ **43% colostomies**
- ▶ **37% ileostomies**
- ▶ **18% urostomies**
- ▶ **1% jejunostomies**



# Why Ostomy Surgery

- ▶ **Cancer of the colon, bladder or rectum**
  - ▶ **Diverticular disease**
  - ▶ **Inflammatory bowel disease; Crohn's, Ulcerative colitis**
  - ▶ **Inherited conditions; Familial Adenomatous Polyposis**
  - ▶ **Birth defects**
  - ▶ **Abdominal trauma**
  - ▶ **Sphincter malfunction**
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# Temporary Stoma Creation

- ▶ **76,551 Average Temporary Stoma Creation/year (2008-2012)**
  - 46% Colostomies
  - 54% Ileostomies
- ▶ **Annual reversal rate of 65.5%**
- ▶ **Average reversal time of 9 months in VA study**
- ▶ **Ileostomies formed most often to protect a distal anastomosis**






# Major Complications of Reversal

## **Early:**

- Abdominal abscess formation
- Enterocutaneous fistula
- Wound-related complications

## **Delayed:**

- Tumor recurrence
  - Incisional hernia
  - Comorbid conditions; cardiac/respiratory
  - Progression of disease
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# Morbidity of Ostomy Reversal



**Surgical site infections  
(32%)**



**Anastomotic leak  
(12%)**



**Unsuccessful reversal  
(10%)**



**Ileostomy reversal  
overall complication  
rate of 17.3%**

Small bowel obstruction 7.2%

Wound sepsis 5.0%

Required exploratory  
laparotomy to complete  
reversal 3.7%


Mortality .4%


**Consideration of potential  
postoperative complications  
influences the decision to  
reverse temporary stoma**



# History of Ostomy Surgery

- ▶ **Earliest stomas were actually fistulas that developed after bowel perforations.**
- ▶ **1706 historical records indicate a battlefield wound resulting in a prolapsed bowel/colostomy.**
- ▶ **1700s etching of a woman with colostomy; French surgeon constructed a stoma for blockage; a sponge strapped to the abdomen absorbed the output.**
- ▶ **1794 surgeon performed an ostomy on an infant with imperforate anus, the child lived to be 45 years old.**

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- **1800s** Development of anesthesia advanced colorectal cancer procedures; increased use of diverting stomas and resection of anal/rectal cancers.
  - **Early stomas** were “loop” construction but were difficult to control and often retracted.
  - **1888** Development of the support rod; stomas were opened with a cautery after skin tissue had attached.
  - **1900s** APR procedure advanced to include resection of lymphatics and perirectal tissue. This procedure was the procedure of choice until guidelines for curative resection were revised. Patients were taught to irrigate the ostomy to gain control and contain feces and odor. This practice continued until the 1980s.

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- **1950s Dr. Bryan Brooke developed the Brooke stoma still used today. The stoma was surgically matured and constructed to be protruding and not flat to the skin level.**
  - **1900s Henry Hartmann developed the Hartmann's procedure still used today. The procedure involves removal of diseased section of bowel, closure of the distal stump and formation of an end colostomy.**
  - **Dr. Mikulicz-Radecki advocated the “double barrel colostomy” consisting of a proximal colostomy with distal mucous fistula. This created two stomas and was difficult to manage and is not widely used today.**




# Ileostomy

- **First ileostomy performed in early 19<sup>th</sup> century. Constructed at skin level; many complications and mortality.**
- **1912 Development of protruding stoma improved outcomes.**
- **1950s Development of Brooke stoma.**
- **1969 Dr. Nils Kock introduced the continent ileostomy.**
- **Barnett Continent Ileal Reservoir**
- **Pelvic pouch (ileal anal reservoir) met with limited success.**



# Urinary Diversions

- ▶ Ureterostomy was simple procedure but difficult to control urine; high incidence of infection.
  - ▶ Ureterosigmoidostomy meant no stoma but problems with kidney infection, incontinence, metabolic complications, development of malignant lesions.
  - ▶ 1950 Dr. Bricker introduced the Ileal Conduit; standard of care today; manageable.
  - ▶ 1950s Continent Urinary Diversion
  - ▶ 1985 Neobladder
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# Ostomy Appliances

- ▶ **Leaves, grass, straw, rags, rubber or leather pouches strapped to the abdomen.**
- ▶ **1912 Mary Manney filed a patent for a surgical appliance secured to the body.**
- ▶ **1920s Dr. Alfred Strauss developed a rubber pouch held in place by adhesives and belts.**
- ▶ **1960s Dr. Rupert Turnbull and Dr. George Crile were instrumental in use of plastics.**
- ▶ **Discovery of karaya and hydrocolloid instrumental in development of ostomy appliances.**






# Enterostomal Therapy

- **Norma Gill (1920-1998)**
  - **Informally counselled ostomates in her home town.**
  - **Dr. Rupert Turnbull, Cleveland Clinic recruited Norma to assist with ostomy care for his patients.**
  - **October 1958 marked the start of Enterostomal Therapy.**
  - **Norma worked tirelessly counseling patients in Ohio.**
  - **Norma worked with Dr. Turnbull to design and manufacture ostomy supplies.**
  - **1961 School of Enterostomal Therapy at Cleveland clinic, requirement: be an ostomate.**
  - **1992 the IAET became WOCN.**
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# Preoperative Visit

- ▶ Establish a relationship between patient and WOCN.
  - ▶ Assess the readiness of the patient and family to receive education regarding care.
  - ▶ Outline usual routines after surgery.
  - ▶ Use audiovisuals if appropriate.
  - ▶ Demonstrate use of pouching system.
  - ▶ Place wafer and pouch on patient if appropriate.
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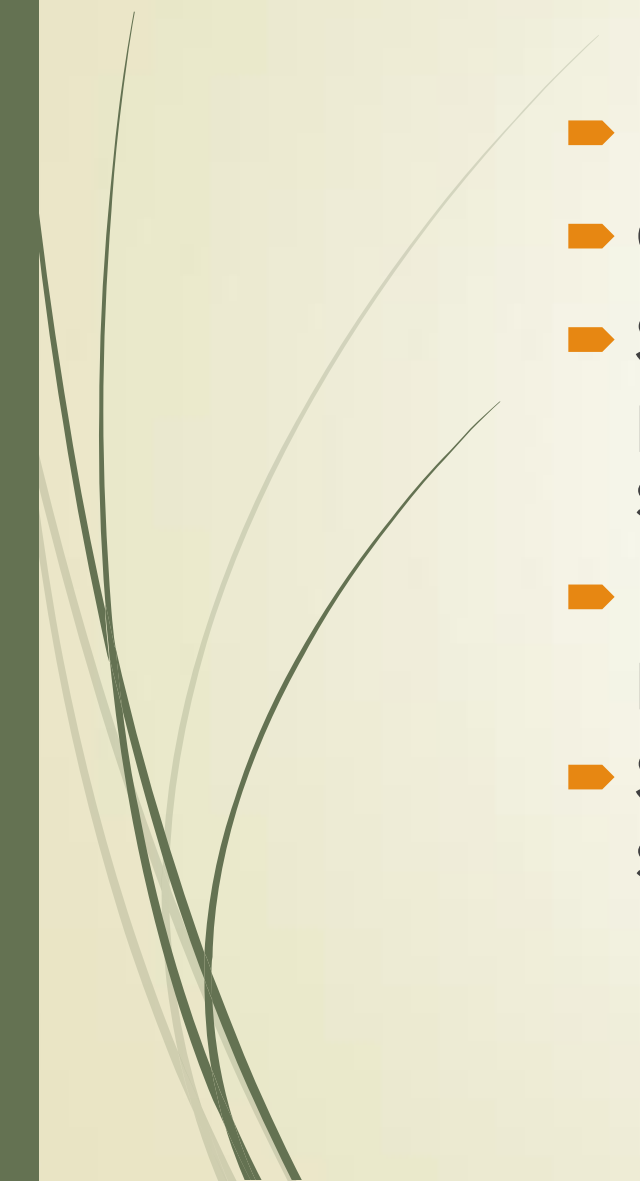


# Pre-Operative Considerations

- ▶ WOCN Society and ASCRS Position Statement on Preoperative Stoma Site Marking for Patients Undergoing Colostomy or Ileostomy Surgery (2014)
  - ▶ Stoma site selection should be a priority during the preoperative visit.
  - ▶ Marking enables optimal site, which reduces postoperative problems-leakage, peristomal dermatitis and difficulty with self care.
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# Stoma Site Marking

- ▶ Located within the rectus abdominis muscle
  - ▶ Consider issues such as wheelchair, contractures
  - ▶ Spend time examining abdomen: protruding or pendulous abdomen, abdominal folds/wrinkles, other stomas, scars, hernias
  - ▶ Patient situation: Age, eye sight, prior stoma, patient preference about location, dexterity
  - ▶ Surgical considerations: surgical procedure planned, surgeon's preference
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# Stoma Site Marking


- ▶ Examine abdomen; with clothes on is optimal
  - ▶ Mark spinal cord patients in their usual position
  - ▶ Examine exposed abdomen sitting, lying, standing and bending over if possible
  - ▶ Determine where the surgical incision might be
  - ▶ Multiple stoma sites require two different planes
  - ▶ Identify rectus muscle; have patient cough to help locate the muscle
  - ▶ Place mark below the belt line if possible
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# Site Marking

- ▶ Locate the infraumbilical fat pad
  - ▶ Place ostomy wafer and have patient sit up
  - ▶ Chose an area that the patient can see
  - ▶ Mark right and left abdomen
  - ▶ Allow 2-inch flat surface around the stoma
  - ▶ Mark selected site with surgical marking pen, cover with transparent dressing
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# Immediate Post-Operative Period Early Stomal Complications


- ▶ **Improper Stoma Site Selection**
- ▶ **Vascular Compromise**
  - ▶ Early stomal necrosis-2.3-17%
  - ▶ Interruption of arterial supply to bowel
  - ▶ Poor collateral blood supply due to creating length of stoma
  - ▶ Dark, grayish or black stoma
  - ▶ Mucosal sloughing
  - ▶ Treatment: diligent assessment/surgery if necrosis appears





# Early Stomal Complications


## ▶ Retraction

- ▶ Result of tension on the bowel or mesentery
  - ▶ Malnutrition, obesity, corticosteroid therapy
  - ▶ Result of complete mucocutaneous separation
  - ▶ Complete acute retraction requires immediate surgical revision to prevent peritonitis and sepsis
- 



# Early Stomal Complications

## ▶ **Peristomal Skin Irritation**

- ▶ Incidence ranges from 3-42%; mild dermatitis to necrosis
  - ▶ Result of chemical dermatitis and desquamation of peristomal skin from leakage and frequent wafer changes
  - ▶ Treatment with cream is difficult; antifungal powder helps
  - ▶ 3-7 days pouch changes can be achieved with properly constructed stoma and correct appliance
  - ▶ WOCN instrumental in treatment and patient education
- 



# Early Stoma Complications

- ▶ **Peristomal Infection, Abscess, Fistula**

- ▶ Uncommon 2-14%; most often with stoma revision or reconstruction at same site
- ▶ Local folliculitis or recurrent inflammatory bowel disease; perforation of the colon, infected hematoma; infected suture granuloma
- ▶ Fistula near ileostomy stoma in Crohn's 7-10%



# Early Stoma Complications

- ▶ **Acute Parastomal Hernia/Bowel Obstruction**
  - ▶ Incidence 5-13%
  - ▶ Technical complication requiring urgent operation
  - ▶ Symptoms include lump, nausea, emesis, fever leukocytosis, presence of air-fluid levels on x-ray



# Early Stoma Complications

## ▶ **Technical Errors**

- ▶ “wrong-end up”
- ▶ Symptoms: appears as a post op ileus or distal bowel obstruction
- ▶ Bloating, nausea, emesis, no output from stoma
- ▶ Diagnosis: water-soluble contrast enema through the stoma; x-ray
- ▶ Treatment: Immediate surgery



# Long-term Living with an Ostomy

## **Psychosocial adjustment:**

Perform adaptive behaviors to changes in body image and function; preservation of healthy relationships

Absence of psychological disorders

Low negative and high positive affect

Adequate functional status

High satisfaction and well-being in various life spheres

## **Ostomy Adjustment Inventory-23**

## 8 Things I wish I'd Known About Having a Colostomy Bag

1. **Do not always trust the nurse's advice.**

- **Always take medical advice.**
- **Adjustment is different for everyone.**






## **2. Play by the eating rules, to a degree.**

- ▶ Be aware of food lists given to you before surgery.**
- ▶ Trust your gut when you try foods not on the list.**
- ▶ If your body doesn't like it, it will tell you.**
- ▶ Let people know what you absolutely cannot eat.**
- ▶ Ask questions in restaurants.**





### **3. Honestly, nobody really cares.**

- ▶ Harsh but true.**
  - ▶ You are not different to them as a person.**
  - ▶ Your ostomy does not really affect their life.**
  - ▶ Let people know if you think it is important.**
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**4. Don't be afraid to get it out, within reason.**

- ▶ **Gives people a glimpse and stops it being a dirty secret.**





**5. Take the pressure off dating with some planning.**







## 6. There really is strength in numbers.

- Ostomy Blogs
- Instagram
- Facebook
- Uncover Ostomy.org
- You Tube
- Support Groups



## 7. Educate and be educated

- ▶ **Family, especially children need to know what an ostomy is and how it works.**
- ▶ **Let children know it is nothing to be afraid of.**
- ▶ **Raise awareness of ostomy surgery.**






## 8. Remember why you have it.

- No more Crohn's flare up.
- No more pain.
- No more missing out on life because of your disease.
- Saved your life.





# Starting A Support Group

- ▶ **Finding Help**
  - ▶ **Planning Your Support Group**
  - ▶ **Starting Your Support Group**
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# Finding Help

## **Look for existing groups.**

\* National organizations, check locally for group, search the internet to see if group exists.

## **Ask other groups how they got started.**

## **Seek out professional assistance before you start a support group.**

\*Social Workers, Clergy, Physicians, Therapists



# Planning Your Support Group

## **Understand your motivation for starting a support group.**

\*Not for your personal support. Define mutually agreed goals.

Ensure that everyone in your group will have the support they need.

## **Determine the scope of your group.**

\*Know what you want the group to be/do; not too restrictive or too general

## **Determine whether your group will be short or long-term.**

Are issues to be discussed long-term or temporary.

## **Consider how often your group should meet.**



## **Determine your group's format.**

\*Topic-based, Open forum

## **Find suitable meeting place and time.**

\*Fee or low cost: church, library, hospital, community center. Set chairs to encourage discussion. Suitable size for your group.

## **Reach out to like-minded people**

\*Consider age, send out information, have interested people call you so you can explain the group.

## **Advertise your support group's meetings**

\*Send out notices weeks in advance



# Starting Your Support Group

## **Run meetings efficiently.**

\*Make group's objectives clear, start and end on time and keep to schedule.

## **Draft a statement of purpose.**

\*Brief and to the point, focus on intended outcomes, do not make any promises of success.

## **Share responsibilities.**

\*delegate to the group members if applicable (topics, snacks)

## **Choose a name for the group if appropriate.**

\*Make mailing lists of participants' contact information if appropriate.

## **Publicize and run your first meeting.**

## **Make plans for future meetings.**



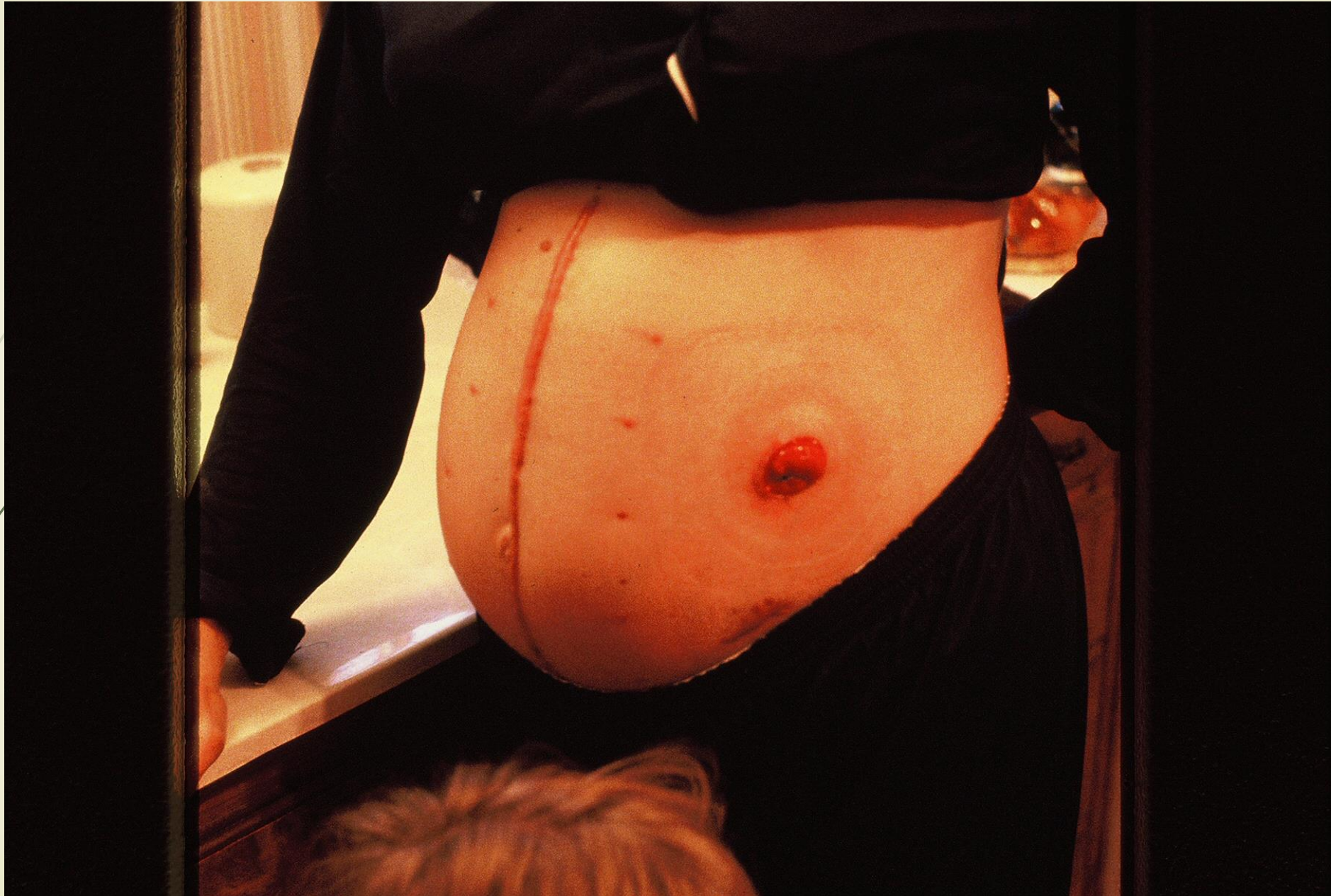
# Who Has an Ostomy?







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# You Tube Ostomy

- ▶ Things They Don't Tell You About Ostomy Surgery
  - ▶ Dealing with Embarrassing Ostomy Moments
  - ▶ How to Change Your Ostomy Bag: Ostomy Care Tips
  - ▶ How to Change Your Ostomy Bag
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