Ostomy Care

Philadelphia Ostomy Association Meeting

3/8/26

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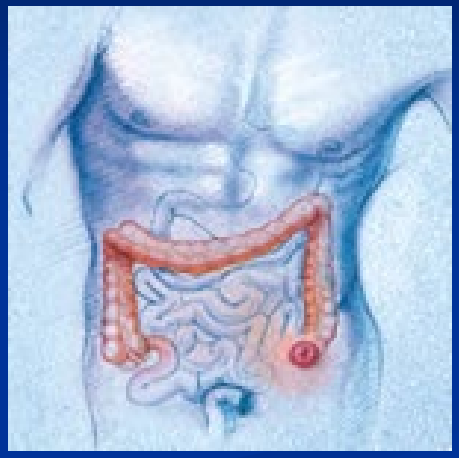
WHY do patients need stomas?

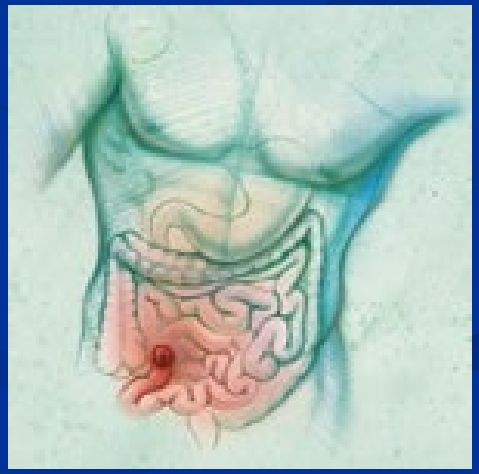
- Bowel Diversion
  - Tumor blockage
  - Refractory issues with pelvic floor / bowel control
- After surgery
  - Unsafe to reconnect after a resection
  - Nothing to reconnect to after a resection
  - Protection of a higher risk reconnection

Fecal Diversions

- Colostomy
  - Opening in the large intestine
  - Hartman's pouch – rectal segment closed off until reanastomosed
- Ileostomy
  - Opening in the small intestine
- Usually Temporary
  - Depending on how long healing needed
  - Usually 2-3 months

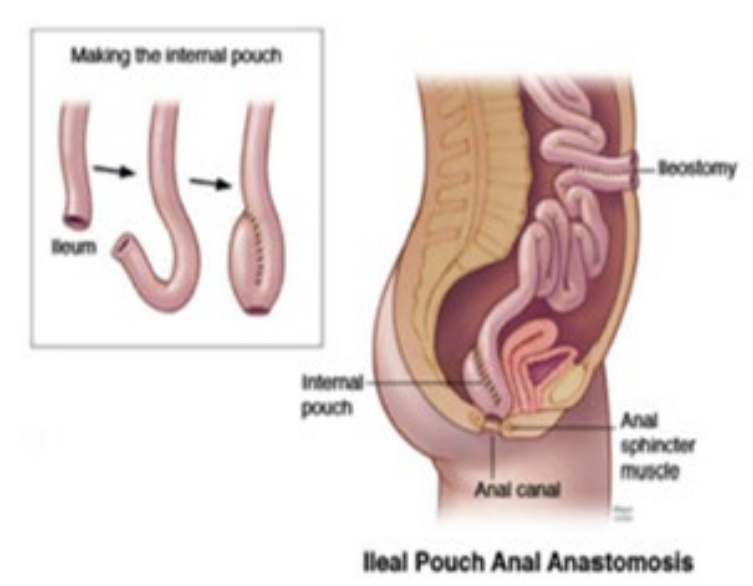


Colostomy



Ileostomy

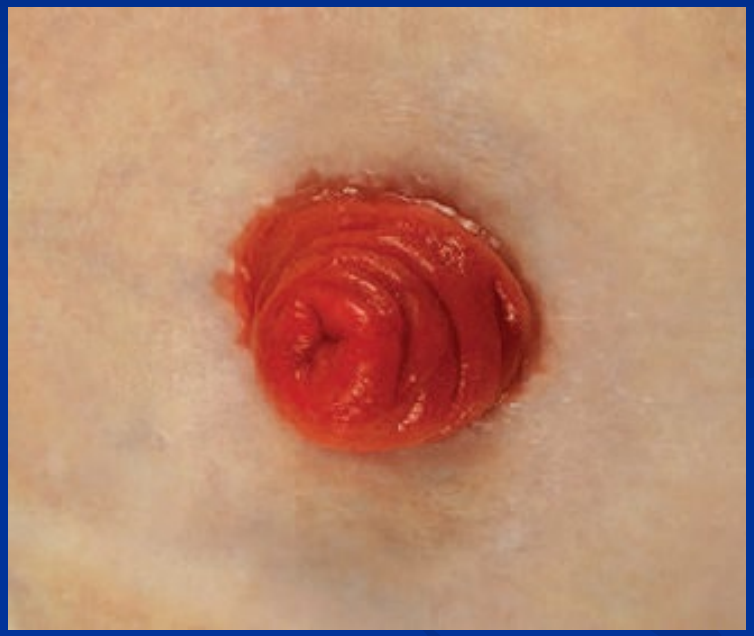
Ileal pouch-anal anastomosis (IPAA) Surgery - J pouch



- Patients who require complete removal of the colon and rectum (UC and FAP) are candidates.
- After colon and rectum removed, the end of the small intestine (ileum) is used to create an internal pouch that is attached to the anal canal.
- A temporary diverting loop ileostomy (DLI) is created.

Healthy Stoma

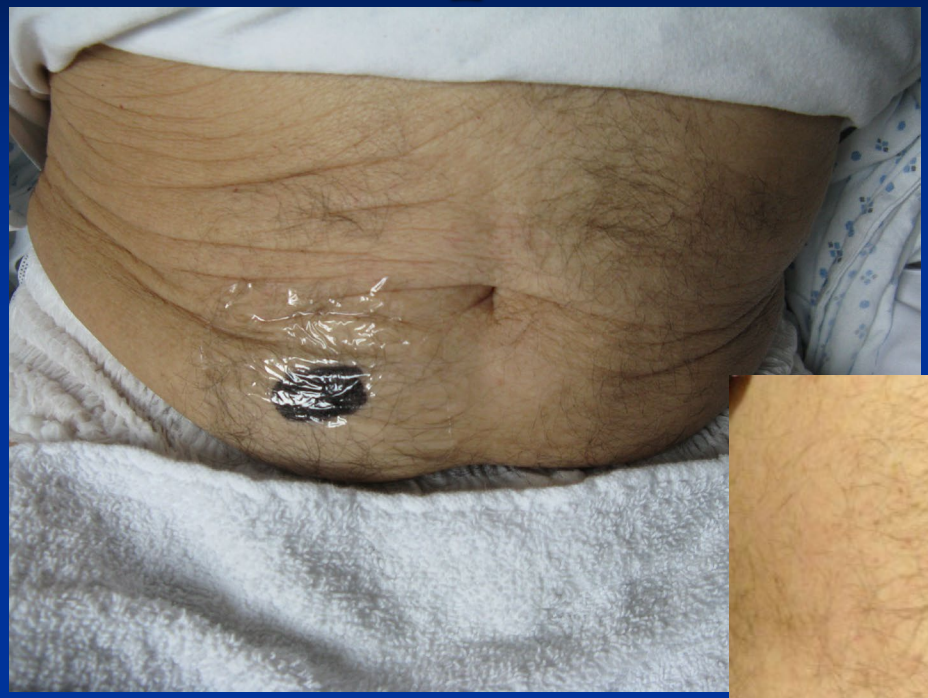
- Red, moist
- No pain
- Size shrinks by 30% in first 4 weeks
- Skin around stoma should be intact without redness or irritation

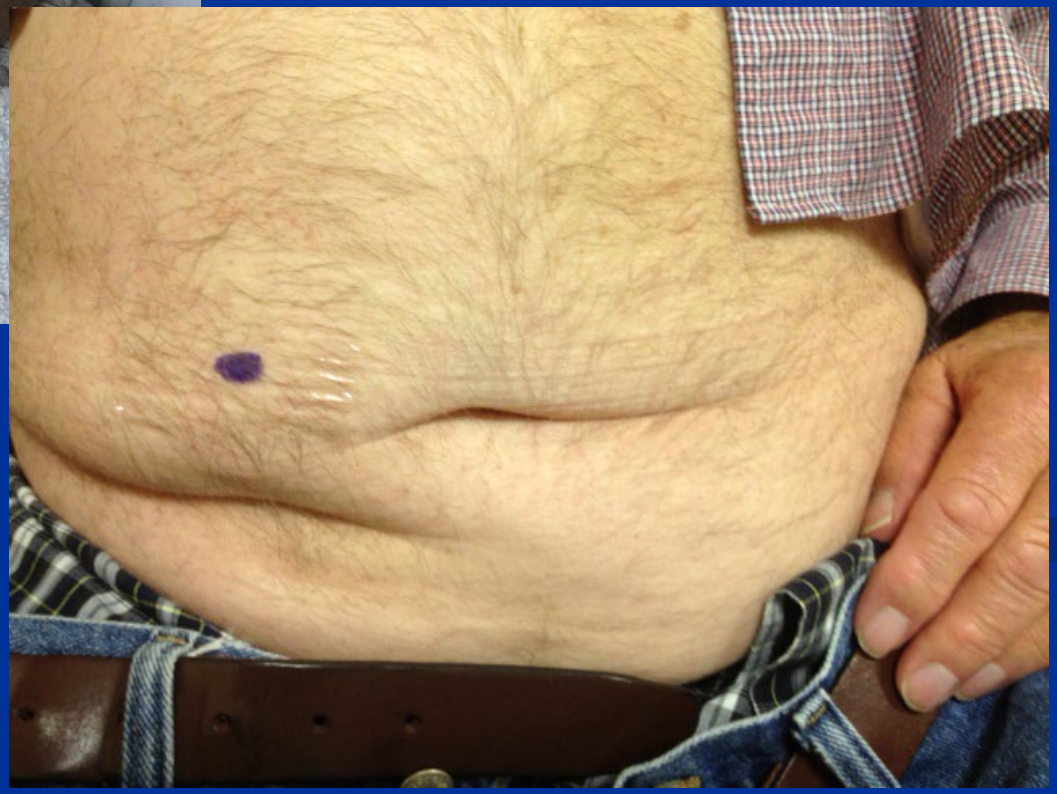


Stoma Site Selection

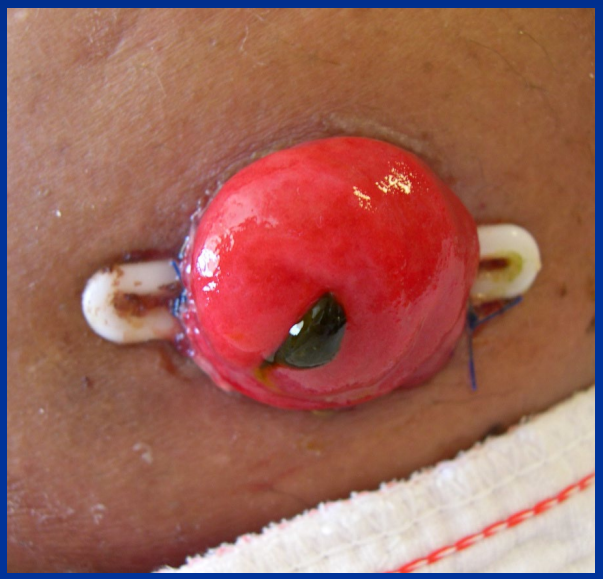
- Ideally done preoperatively by CWOCN
- Quadrant determined by surgery
  - Ileostomy (RLQ)
  - Sigmoid Colostomy (LLQ)
  - Transverse colostomy (upper quadrants)
- Assess patient while supine, sitting and standing
- Assess while wearing their clothes
- Avoid skin folds, belt line, scars
- Visible to patient (esp. if protuberant abdomen)

Preop stoma site marking



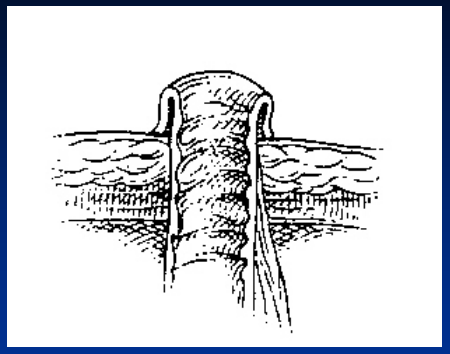


Construction of Stoma

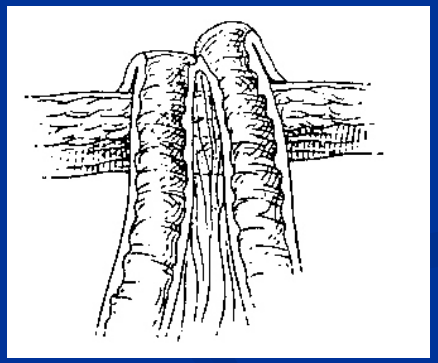


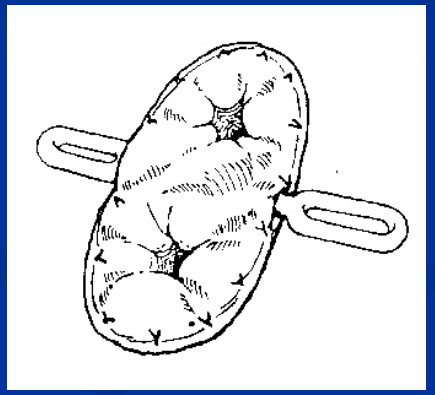
Bar usually removed POD # 3-4

End stoma

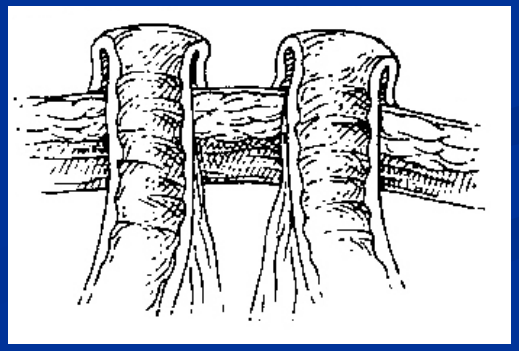


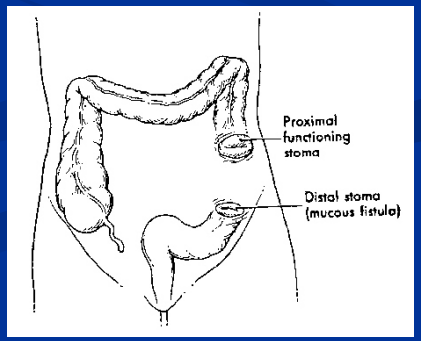
Loop stoma



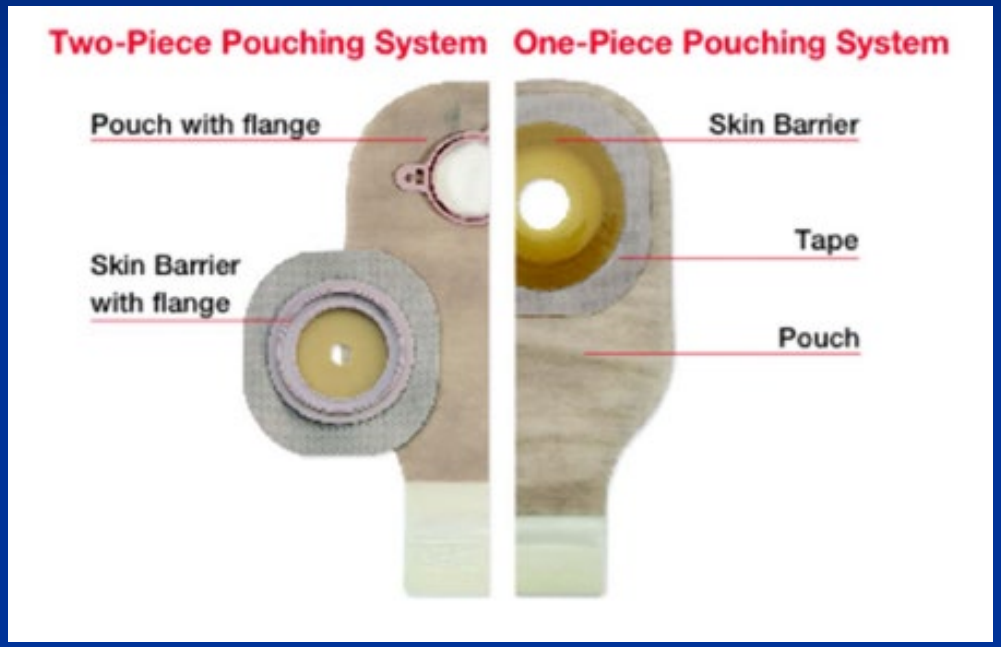


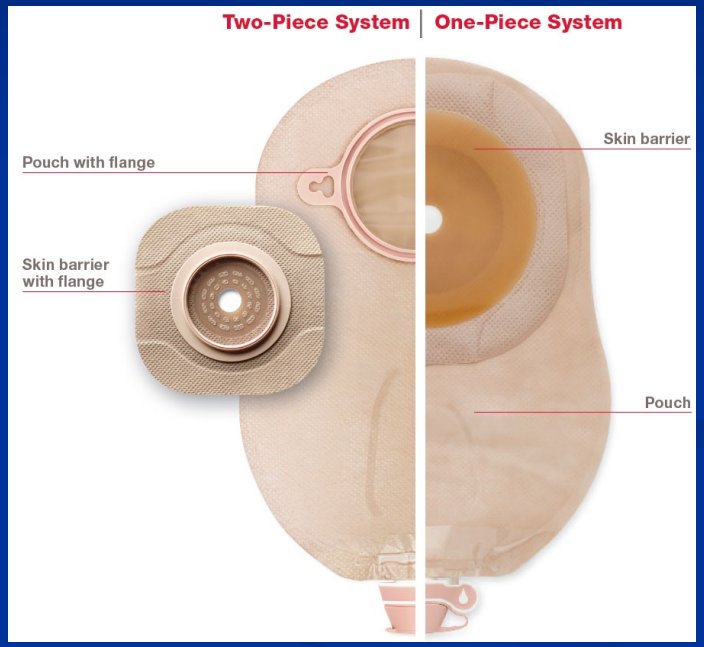
Double barrel stoma





Pouching Options

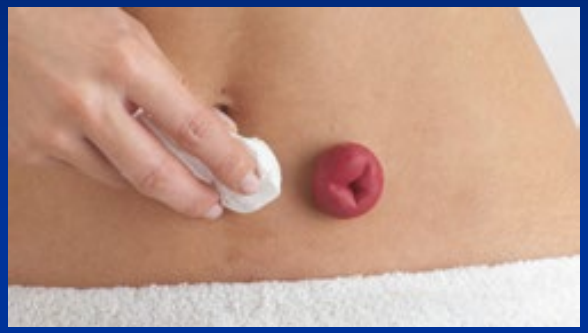




Care of an Ostomy

- Requires wearing external pouch
- Pouch is emptied when 1/3 to ½ way full
- Skin barrier (wafer) is changed every:
  - 3-4 days (ileostomy)
  - 4-5 days (colostomy)
  - 3-4 days (urostomy)
- Patient may shower, swim, be active, have sex
- Patients' Concerns
  - Odor
  - Leakage
  - Will anyone know I have one?

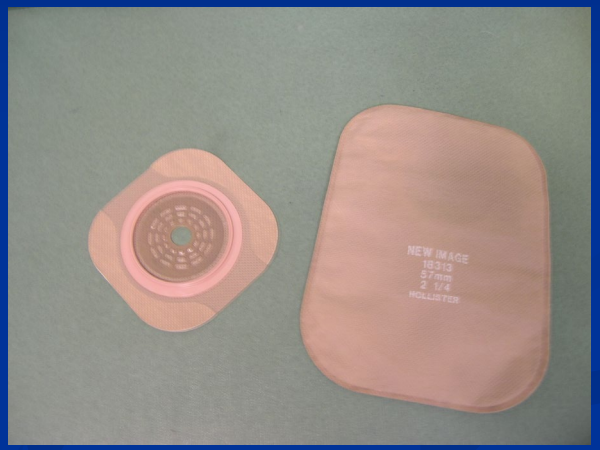
Changing an ostomy appliance



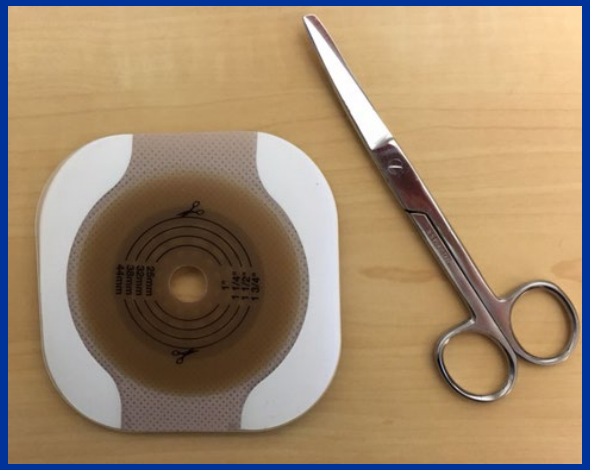


Common ileostomy/colostomy pouching options
1 pc vs 2 pc; drainable vs. closed

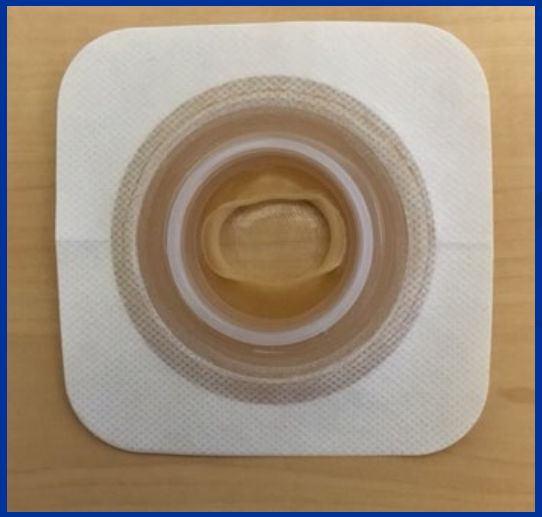


Skin Barriers (also called wafers)

Cut to Fit



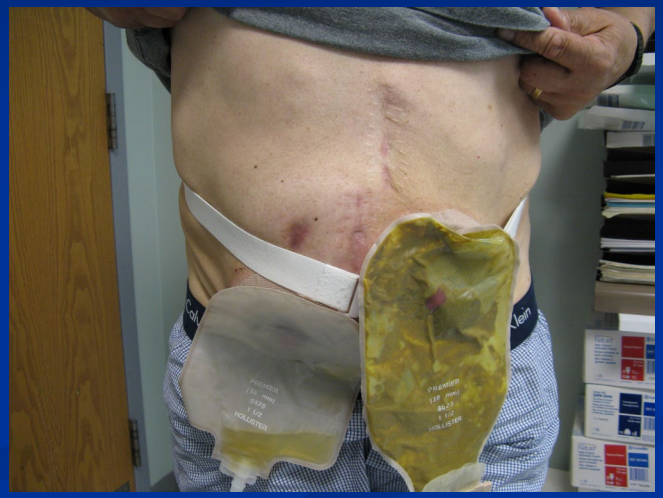
Moldable

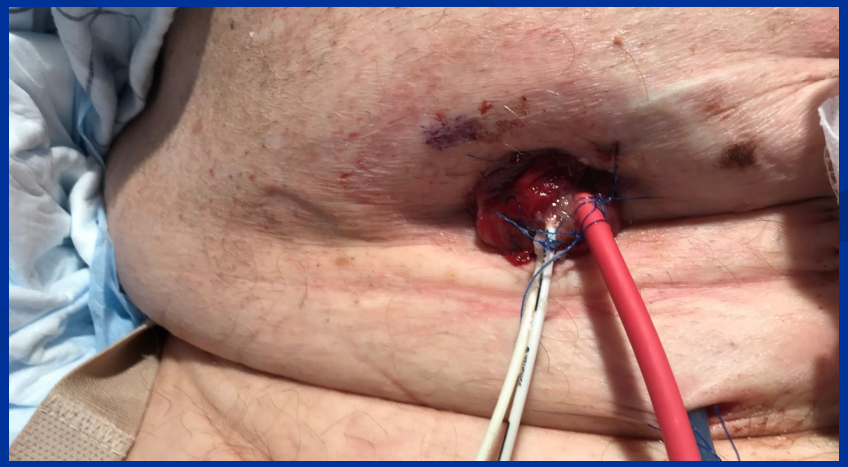


Precut

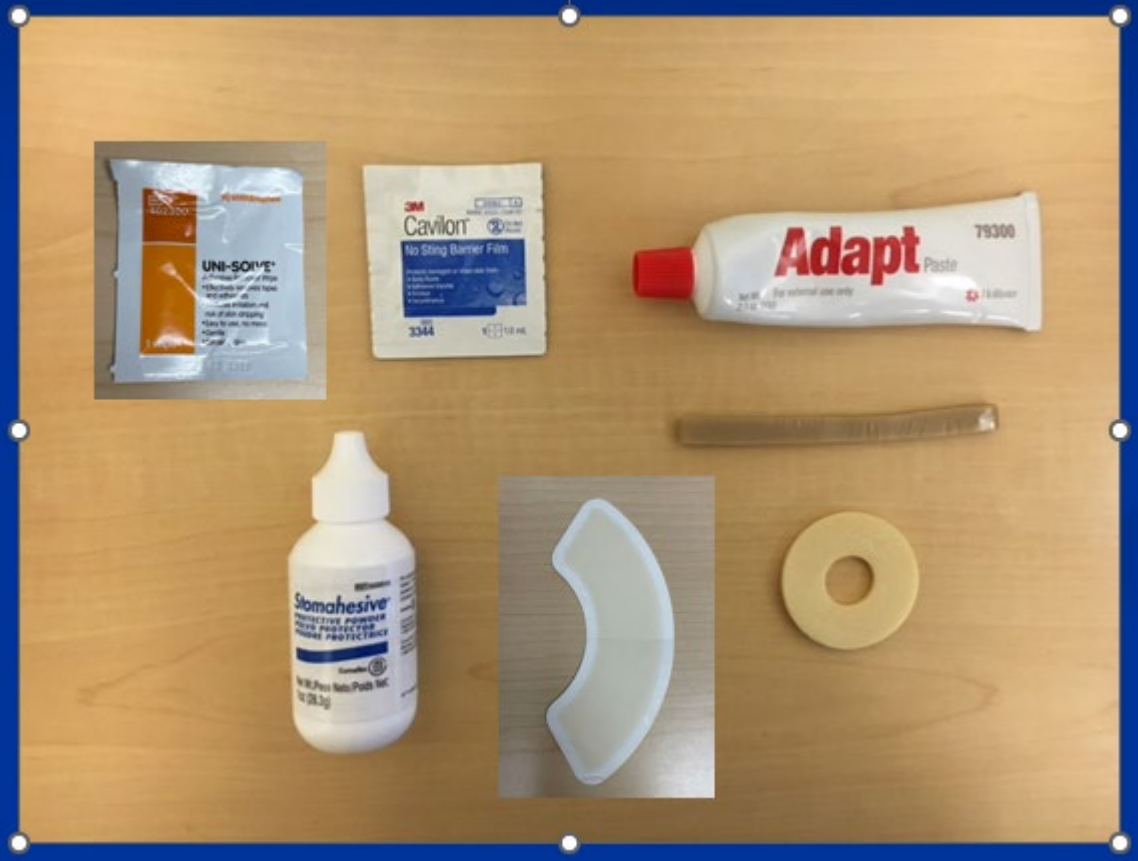
Convex Wafer

- Solves a lot of problems
- Used for flush or retracted stomas
- Used to “fill in” the peristomal dip or flatten out a nearby fold
- Can increase convexity by adding a belt





Other Accessories



Obtaining supplies

- Patient goes home with script/checklist of supplies
- Home Care RN *usually* helps place order for supplies
- Surgeon's office signs authorization for insurance coverage
- Insurance Coverage
  - 10 wafers/month
  - 10-20 drainable pouches or 60 closed pouches/month
  - If no insurance – pts can apply for Medical Assistance
    - Can take 6-8 weeks to get Medical Assistance
    - Some pts come to ED when out of supplies

Main Goals with Diet

Colostomy

- Avoid gas
- Avoid odor
- Avoid constipation

Ileostomy

- Avoid gas
- Avoid odor
- Avoid blockages
- Avoid dehydration

Dietary influences on stoma function

Increase odor	Increase gas	Thicken stool	Loosen stool
Beans	Beans	Apple sauce	Green beans
Asparagus	Beer, carbonated soda	Bananas	Beer
Broccoli	Broccoli	Cheese	Broccoli
Brussel sprouts	Brussel sprouts	Boiled milk	Fresh fruits
Cauliflower	Cauliflower	Marshmallows	Grape juice
Cabbage	Cabbage	Pasta	Raw vegetables
Eggs	Corn	Creamy peanut butter	Prunes
Fish	Cucumbers	Pretzels	Spicy foods
Onions	Mushrooms	Rice	Fried foods
Some spices	Peas	Bread	Chocolate
	Radishes	Tapioca	Leafy green vegetables
	Spinach	Toast	Spinach
	Dairy products	Yogurt	

Controlling Excess Gas

- Avoid using a straw.
- Chew foods well.
- Avoid chewing gum.
- Avoid smoking.
- Eat meals regularly: 4 – 6 small meals
- Muffling with clothing layers & light pressure
- Venting with filters
- OTC agents (Beano and Gas-X)

- *Gas poofs up bag!!*
- *Gas makes noise.*
- *Pouches with filters help vent and deodorize gas.*

Avoiding Excess Odor

- Pouches are odor proof.
- Keep tail of pouch clean.
- Colostomy output is odorous. Ileostomy not so much.
- Colostomates may prefer disposable pouches.
- There are deodorant products (room sprays, drops, lubricating gels) that can be added to pouch.

Colostomy
Preventing constipation

- Ingest sufficient fiber and fluids to prevent constipation.
- Drink 1.5 – 2L liquids every day.
- Exercise
- Usually on stool softener postop
- May occasionally need a laxative (e.g. Miralax).
- Avoid stimulant laxatives (e.g. Senna).
- Distal colostomies may need to irrigate to alleviate constipation.

Pancaking of stool can be an issue. Consider one pc disposable pouch.

Colostomy Irrigation

Instillation of 500 – 1000 ml tap water into sigmoid or descending colostomy on a routine schedule (daily or every other day); the resulting bowel distention stimulates peristaltic activity causing distal colon to empty.

Ileostomy
Avoiding dehydration

- Dehydration affects 30% of patients with DLI; most common cause of readmission.
- Goal for ileostomy output early postop should be about 1000 – 1200ml over 24 hours (emptying pouch 5-7 X/day).
- NO stool softeners, laxatives or enemas for ileostomates
- Drink plenty of fluids. Drink more during periods of high volume output or heavy sweating.
- Preferred fluids - water, broth, veggie juices, pediatric electrolyte solutions (e.g. Pedialyte preferred to sports drinks).
- Avoid foods that can cause diarrhea
- Eat foods that help thicken stool when stool is loose

Managing high ileostomy output (> 1.5 L/day)

- Soluble viscous, nonfermenting, gel-forming fiber supplement (e.g. psyllium husk) can slow transit time by absorbing water and forming a gel-like consistency.
- Anti-motility agents (e.g. loperamide [Imodium], diphenoxylate and atropine [Lomotil], octeotride, cholestryamine and rarely tincture of opium)
- Long term IV hydration
- Consider early reversal if feasible

Ileostomy
Avoiding blockages

- Chew food well
- Drink plenty of liquids
- Avoid large amounts of insoluble fiber foods that may cause blockages (4-6 weeks)
  - raw fruits, raw vegetables, nuts, popcorn, foods with seeds or skins, meats with casings
  - coconut, mushrooms, black olives, stringy veggies, celery, dried fruits
  - tough meats
- Bananas, canned fruit, smoothies, smooth applesauce and veggies cooked until soft are OK

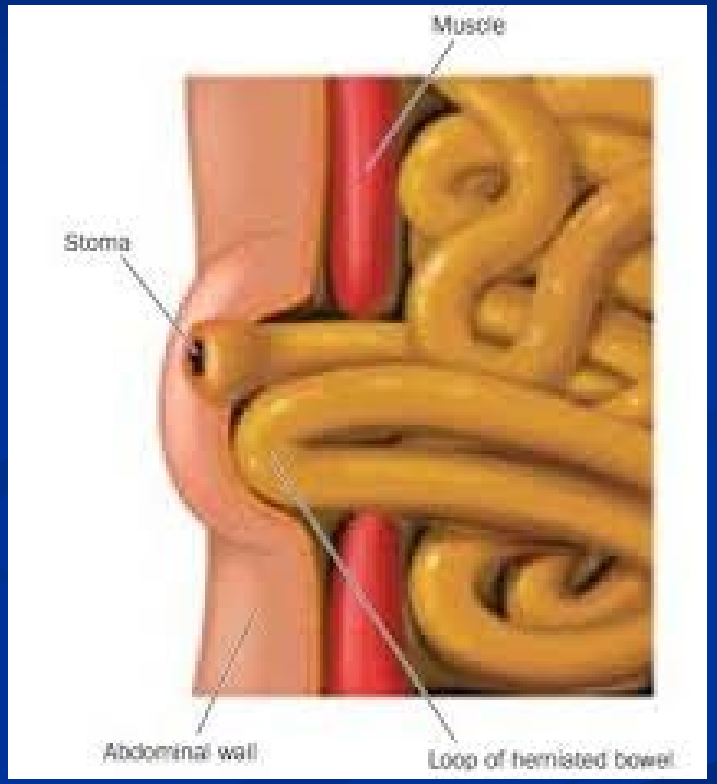
Stoma Complications

Parastomal Hernia

Prevention and Management

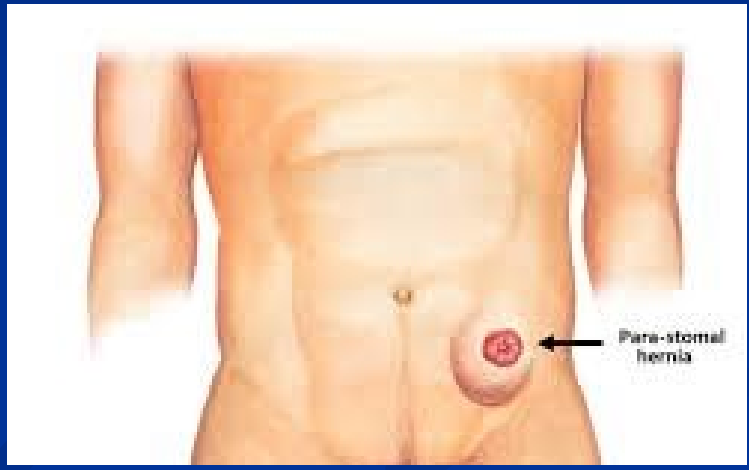
What is a parastomal hernia?

- A parastomal hernia occurs when the intestines push through the abdominal muscles around the stoma. A bulge may appear around the stoma.
- The surgery to create the stoma starts that weakness in the abdominal muscle - so hernias are fairly common.
- Most parastomal hernias are not dangerous, but in rare cases, they can become life threatening.
- The bulge may cause some people to have trouble getting a good seal from their ostomy appliance.



Signs of a Parastomal Hernia

- A bulge forms on your abdomen around your stoma.
- The bulge may get bigger and smaller as you change positions. It may go flat (or "reduce") when you lie down and get bigger when you stand up or cough.
- The bulge can feel soft or hard.
- For people who have colostomies or ileostomies, the bulge can get hard right before stool is expelled.
- The bulge may make it more difficult to get a good seal to your appliance.



Risk Factors

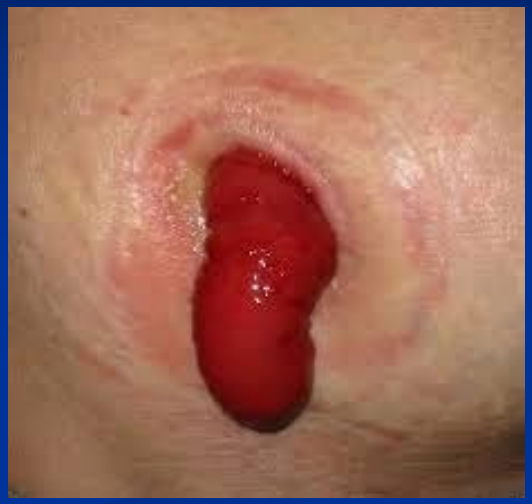
- Being overweight or obese is the # 1 cause
- Smoking
- Not exercising; having weak abdominal muscles
- Heavy lifting
- Not lifting things properly
- Coughing or sneezing
- Having abdominal surgery
- Having ostomy surgery

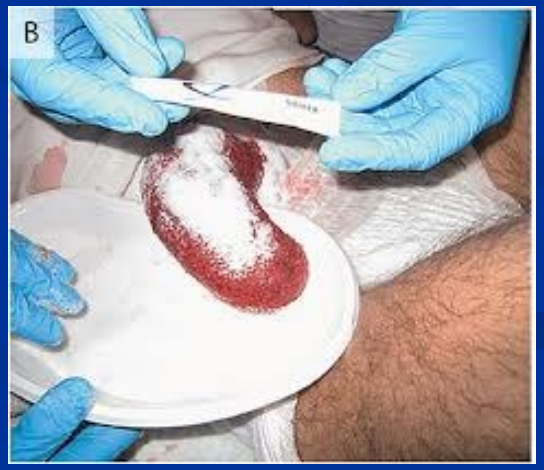
Is a parastomal hernia dangerous?

- A parastomal hernia that does not cause pain or blockage symptoms is not dangerous.
- Although some people describe a mild ache or dragging feeling, most hernias are not painful.
- If you do have severe abdominal pain, nausea, vomiting or your stoma turns to a dark color - that is serious and you should go immediately to an Emergency Room. These may be signs of a strangulated hernia - which mean blood flow to the intestine is being cut off.
- A strangulated hernia is unusual - but is possibly life threatening.
- Hernias can also cause stoma prolapse.

What is Prolapse?

- Prolapse is when the stoma "telescopes" in and out becoming either longer and/or wider in diameter.
- Prolapse is common with a hernia.
- The prolapse may "reduce" when lying flat - but is likely to pop out again.
- The prolapse can sometimes be gently pushed back.
- One technique sometimes used to reduce a significant prolapse is applying table sugar to the stoma.
- Surgery is considered if the stoma becomes excessively long or big, or if there is discoloration of the stoma, or pain.
- Remember to cut your wafer opening to the biggest diameter size you stoma gets. You can use the "donut"/barrier ring to protect any exposed skin.





Tips to try and prevent a parastomal hernia

- Try to maintain a healthy weight. Try and lose weight if you are overweight.
- Try to cut back or quit smoking.
- Before surgery - increase the amount of cardio exercise you do.
- After surgery - increase activity level as tolerated. Do not overdo it. Take it easy.
- Avoid heavy lifting for at least 3 months. Do not lift anything heavier than 10 pounds (a gallon of milk is about 8 pounds).
- Manage coughing and sneezing.
- Get an OK from your surgeon before starting any intense exercise.

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Recovery

About me+™ recovery series

The me+™ recovery series, provides information and support about the importance of movement and physical activity after ostomy surgery.

Read More

Recovery

Phase 1 - Foundation

If you've ever had ostomy surgery, currently have an ostomy or have had a reversal, then me+™ recovery is for you.

Recovery

Recovery Phase 2

When you've been working through Green Phase 1 for a few weeks and you feel confident with the moves, you're ready to

Recovery

Phase 3 - Getting Fitter

If you've been working through Blue Phase 2 for some weeks and feel ready to progress, then you can move onto the

Is surgery needed?

- Is the stoma reversible? – Most effective treatment
- For hernias that do not cause any significant symptoms (that is, pain or bowel blockages), surgery to fix the hernia is usually avoided.
- Hernia surgery is a big surgery to have and there is a relatively high chance the hernia will come back.
- However, if your hernia is causing pain or bowel blockages - you may need surgery.
- Discuss with your surgeon about whether surgery is needed.

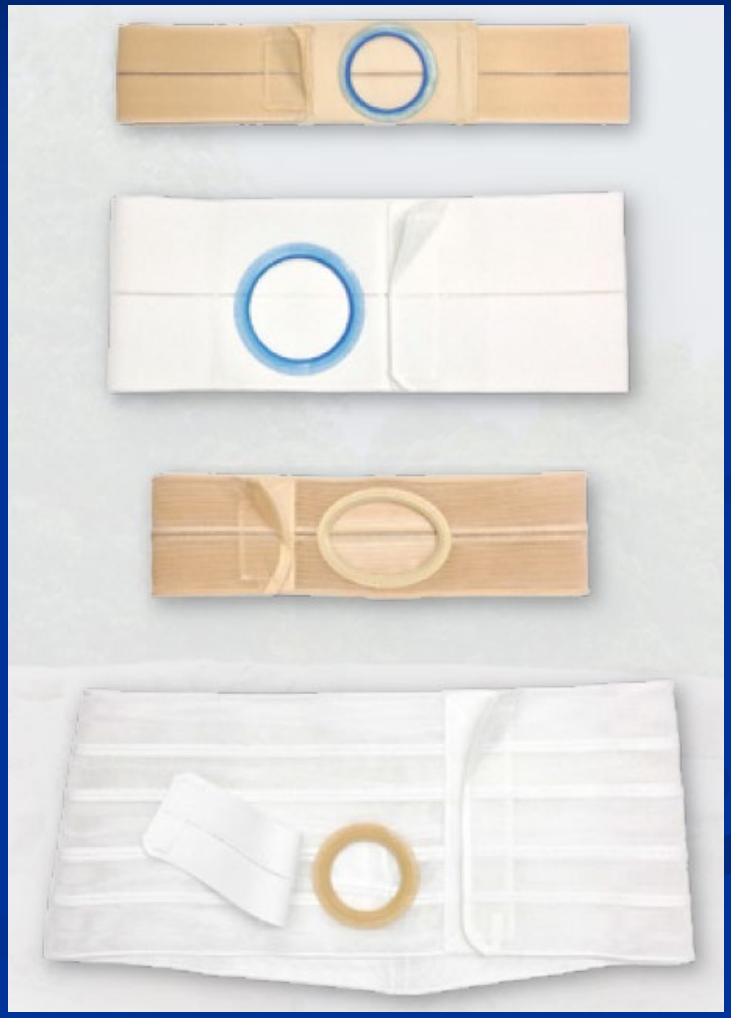
How is the hernia treated if surgery is not needed?

- Most hernias are managed conservatively - by wearing a hernia support belt.
- The hernia belt does not fix the hernia. And it may not prevent it from getting worse.
- But it will support the bulge and ease the ache or dragging feeling caused by the hernia. It will help "tuck in" the bulge.
- Most people wear the hernia belt during the day and not while they sleep.
- Your ostomy nurse can help measure you for a hernia belt.

Nu-Hope hernia belts

Nu-Hope belt with prolapse belt

Hernia Support Belts

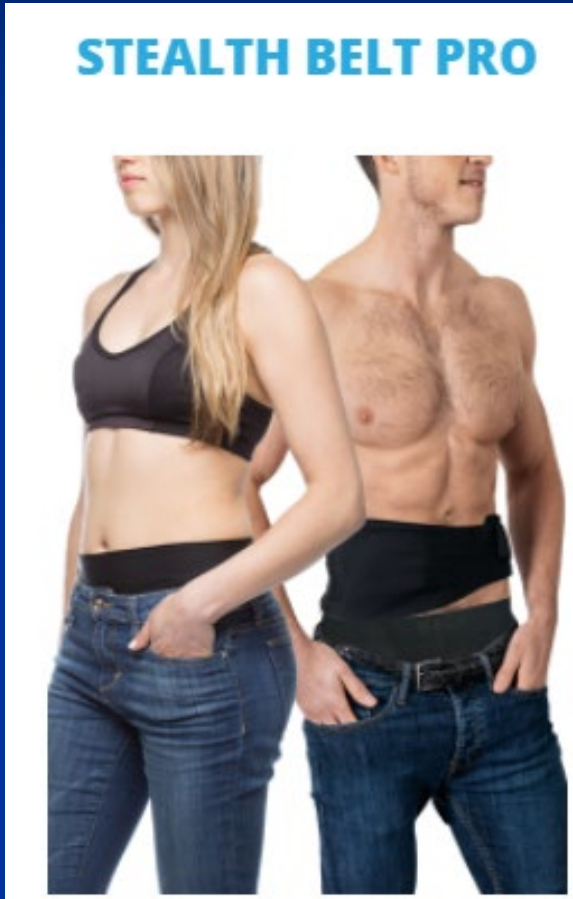


Other hernia belt options

Hernia belts on Amazon

Nu-Hope comfort belts

Stealth belts

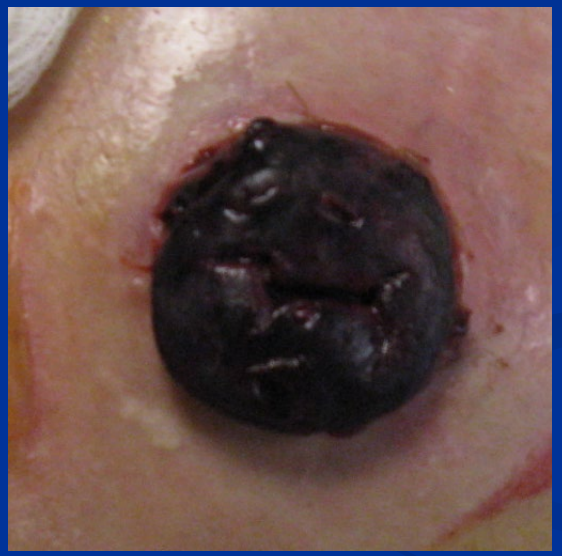


Summary

- Hernias are common after ostomy surgery.
- Most hernias are not dangerous and do not require surgery.
- Managing your weight and avoiding heavy lifting are the best things you can do to prevent a hernia.
- If you think you have signs of a hernia, make an appointment to be checked out with your surgeon.
- If you have a hernia, make an appointment with your ostomy nurse to be fitted for a hernia belt.
- If you have severe abdominal pain or blockage symptoms, go to the Emergency Room.

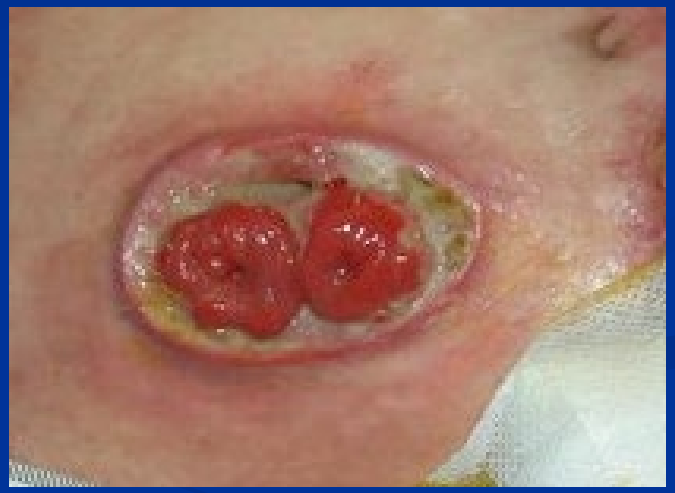
Stoma necrosis

- Death of the stomal tissue resulting from impaired blood flow
- If necrosis extends to the proximal bowel below the anterior fascia → revision required



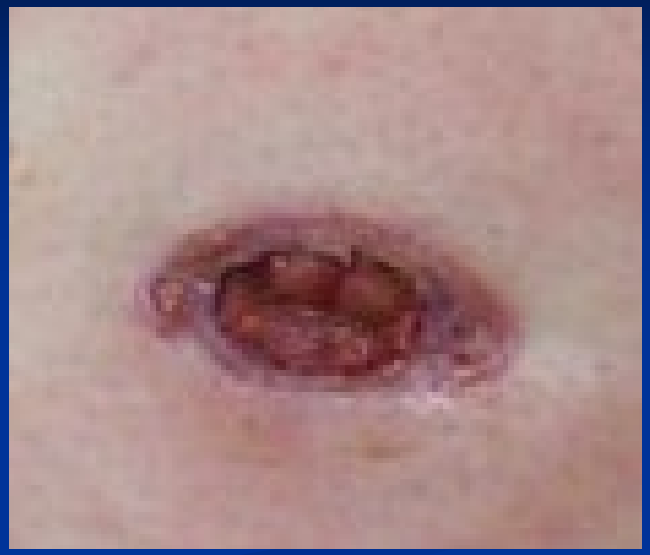
Mucocutaneous Separation

- The detachment of stomal tissue from the surrounding peristomal skin
- Can be partial or circumferential
- Partial – fill in with ostomy powder (OR pack with hydrofiber dressing) and cover with barrier ring
- Circumferential – risk for stenosis; will need revision



Stomal retraction

- The disappearance of normal stomal protrusion in line with or below skin level
- May need convex wafer and belt

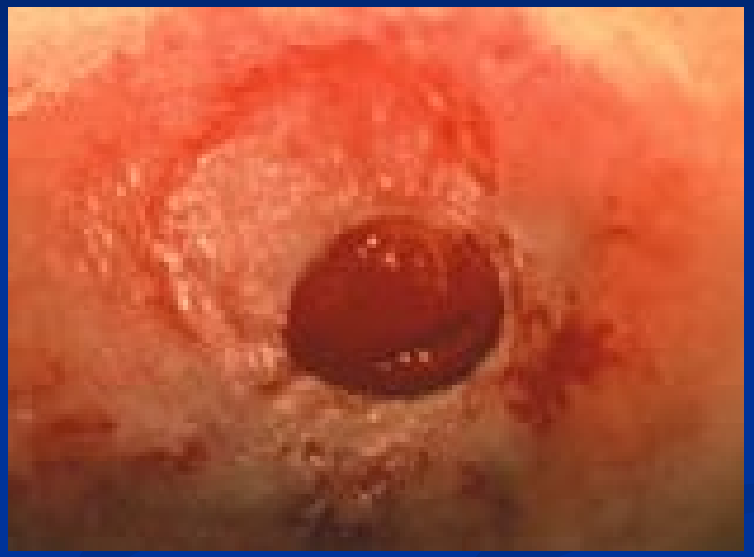


Convex wafer

Peristomal Complications

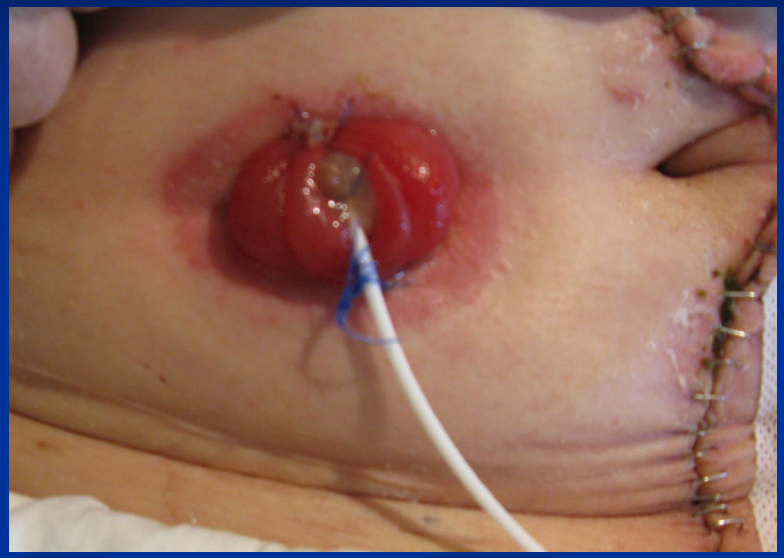
Peristomal irritant contact dermatitis

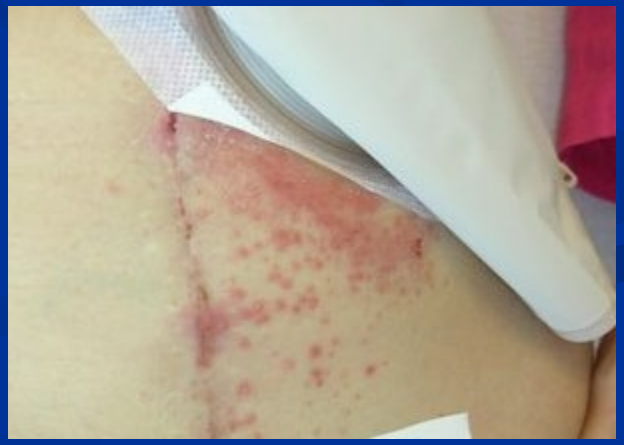
- Damage resulting from skin exposure to fecal or urinary drainage or chemical preparation
- Treatment may include ostomy powder, No sting skin prep and better fitting wafer.



Peristomal candidiasis

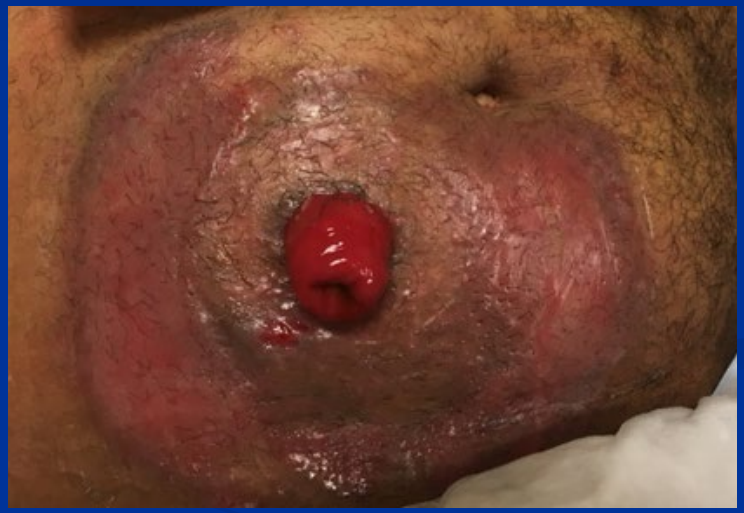
- An overgrowth of fungal organisms (Candida) sufficient to cause inflammation, infection, or skin disease in the peristomal area
- Treat with Nystatin powder





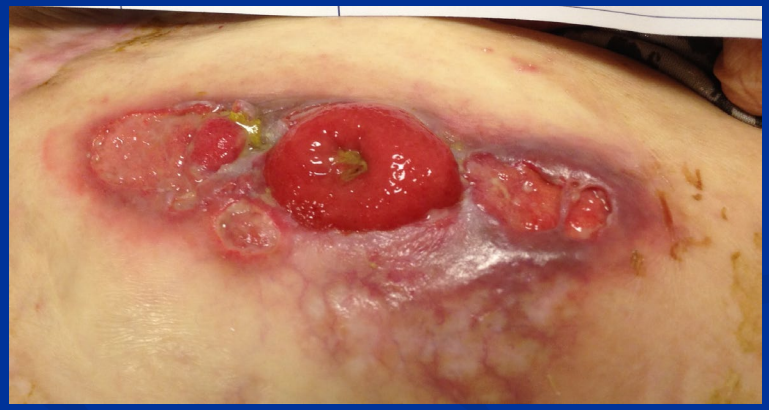
Allergic or Contact Dermatitis

- An inflammatory skin response resulting from hypersensitivity to chemical elements
- Flonase Spray 2-3 sprays 2X/week
- Apply strips of Duoderm dressing on weeping skin
- Find alternative ostomy wafer/product



Peristomal pyoderma gangrenosum

- An ulcerative skin condition of unknown etiology
- Most have IBD
- Full thickness, painful lesions with purplish edge
- Clobetasol 0.05% ointment, Aquacel AG and Duoderm dressings on wounds
- Consult Derm for ILK
- Consult GI to manage IBD flare
- May need stoma relocation



Keys for Success

- Preop site selection
- Postoperative assessment for complications
- Education by CWOCN and Nursing Staff
- Home Care Referral
- Assistance with obtaining supplies
- Vendor support for samples
- Ongoing follow-up
- Support groups