Ostomy Care

Resource: Hollister Incorporated and Perry & Potter

Types of Ostomies

Colostomy

A colostomy is a surgically created opening into the colon, through the abdomen. The purpose of a colostomy is to allow stool to bypass a diseased or damaged part of the colon. To construct the colostomy the surgeon brings a part of the colon through the abdominal wall – the new opening is called a stoma. There are no nerve endings in the stoma, therefore the stoma is not painful. The stoma should always be red and moist and it may bleed easily if it is hit or rubbed. This type of minor, temporary bleeding is normal.

There are four sites along the large bowel where a colostomy can be created:

1. The **Ascending Colostomy** is made from the ascending portion of the colon. The stool consistency from this type of colostomy usually fluctuates between liquid and pasty.
2. The **Transverse Colostomy** is made from the transverse part of the colon. The stool consistency from this type of colostomy usually varies from liquid to pasty to semi-formed.
3. The **Descending Colostomy** is made from the descending part of the colon. The stool consistency from this type of colostomy is almost completely formed stool.
4. The **Sigmoid Colostomy** is made from the sigmoid part of the colon which is just above the rectum. The stool consistency from this type of colostomy is fully formed stool.

Ileostomy

An ileostomy is a surgically created opening into the small intestine, through the abdomen. The purpose of an ileostomy is to allow stool to bypass the colon. The small bowel is composed of the Duodenum, the Jejunum and the Ileum. To construct an ileostomy, the surgeon brings part of the ileum through the abdominal wall. This new opening is called a stoma. There are no nerve endings in the stoma, therefore the stoma is not painful. The stoma should be red and moist, and it may bleed easily if it is hit or rubbed. Generally, an ileostomy stoma is located on the abdomen in the right lower quadrant, just below the waist to the right of the navel. Stool from an ileostomy is generally a liquid type of drainage, however, as the small intestine begins to adapt the stool will become thicker and more paste-like. It is important to remember that the stool from an ileostomy comes directly from the small intestine, so the stool contains digestive enzymes that can be very irritating to your skin.

Urostomy

A urostomy is a surgically created opening on the abdomen that allows urine to flow out of the body. A urostomy may also be called a urinary diversion. The most common type of urostomy is an Ileal Conduit. To create an ileal conduit, the surgeon removes a short

segment of the small intestine – the ileum. This short segment of intestine will be used as a pipeline, or conduit, for urine to flow out of the body. The surgeon closes one end of the conduit, inserts the ureters into the conduit, and brings the open end of the conuit through the abdominal wall. This new opening is called a stoma. The few inches of small bowel that the surgeon removes for the ileal conduit will not affect how the intestine functions. The surgeon reconnects the intestine, and it continues to function just as it did before.

Pouching a Stoma

Equipment Required:

- A two-piece (flange and pouch separate) or a one-piece (flange and pouch attached) cut to fit pouching system
- Adhesive remover wipes
- Clean disposable gloves
- Ostomy deodorant
- Gauze pads or washcloth and towel or waterproof barrier
- Basin with warm water
- Curved scissors
- Skin barrier wipes
- Optional products – tape, ostomy belt, stomahesive powder, stomahesive paste

Procedure:

1. Position patient either standing or supine and drape. If seated, position the patient either on or in front of the toilet
2. Wash hands and apply disposable gloves.
3. Place towel or disposable waterproof barrier under the patient.
4. Remove used pouch and skin barrier gently by pushing skin away from the barrier. An adhesive remover may be used to facilitate removal of the skin barrier.
5. Cleanse peristomal skin (skin around stoma) gently with warm tap water using gauze pads or a clean washcloth – do not scrub skin – dry completely by patting skin with gauze or a towel.
6. Measure the stoma for the correct size of pouching system needed using the manufacturer's measuring guide.
7. Cut an opening in the flange 1/16 to 1/8 inch larger than the stoma before removing the backing from the flange. Remove the backing from the barrier and adhesive border. With an ileostomy and urostomy, apply a thin circle of stomahesive paste around the opening just cut.
8. Apply flange by centering the sized opening over the stoma and attach pouch. If there are creases next to the stoma, fill them with stomahesive paste, let the paste dry for 1 – 2 minutes then apply flange.
    a) For a one piece pouching system:
        1) Use skin sealant wipes on skin directly under the adhesive skin barrier or pouch; allow to dry. Press adhesive backing of system

smoothly against the skin starting from the bottom and working up around the sides.

2) Hold your hand over the system that has just been put in place to ensure a good seal over the skin.

b) If using a two-piece pouching system:

1) Apply flange as outlined in steps above then snap pouch onto the flange and hold your hand over the system to ensure a good seal.

c) For both pouching systems gently tug on the pouch in a downward direction to ensure it is secure.

9. An ostomy belt can be attached at this point for extra security.
10. Although many ostomy pouches are odour-proof, a small amount of ostomy deodorant can be added into the pouch.
11. Properly dispose of old pouch and soiled equipment.
12. Remove gloves and wash hands.
13. Change one or two piece system every 3 to 7 days unless leaking. Leakage should not be the main indicator for a system change. A schedule should be developed for system changes so they occur before leakage can be an issue.

<u>Unexpected Outcomes</u>

- **Skin around the stoma is irritated – has a burning sensation.**
  - ✓ Assess stoma as mucosal layer of stoma separates from the skin.
  - ✓ May be caused by undermining of the pouch seal by fecal contents.
  - ✓ May indicate an allergic reaction, which can be manifested by erythema and blistering, usually confined to one area immediately under the allergen.
  - ✓ Remove pouch more slowly.
  - ✓ **Contact the ET nurse.**
- **A necrotic stoma** is manifested by purple or black colour, dry instead of moist texture, failure to bleed when washed gently, or presence of tissue sloughing.
  - ✓ Assess circulation to stoma.
  - ✓ Determine presence of excessive edema or excessive tension on the bowel suture line.
- **The patient complains of irritation and burning around the stoma.**
  - ✓ Assess skin for breaks in integrity, skin inflammation, maceration, or infection.

Remember – the stoma does not contain any pain receptors, pressure from a flange that is fitting too tightly will show up as a white area on the red stoma. If you see this ensure your next flange is sized 1/8 of an inch larger than the actual stoma size to avoid friction to the stoma.

Contact the ET nurse if you have any concerns related to your patients stoma and ostomy management equipment.