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Stoma Care at a Glance

A concise guide for Community Nurses

Your Local Stoma Care Nurse

Notes

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Introduction

'Stoma Care at a Glance' has been produced as a handy guide to stoma care for nurses working in a primary care setting.

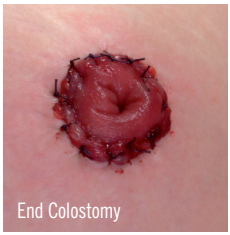
Earlier discharge from hospital and an increasing emphasis on care delivery within the community means that patients with a stoma are more likely to require support from the primary care team.

This booklet provides straightforward information and practical advice on stoma care, as well as guidance on managing some of the common problems and complications which you may encounter.

We hope that you will find it a useful reference.

Contents

Colostomy

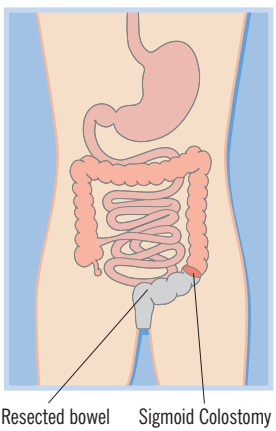

End Colostomy

Normal Output – Formed or semi-formed stool. The higher the colostomy is situated in the colon, the softer and looser and less regulated the output is likely to be.

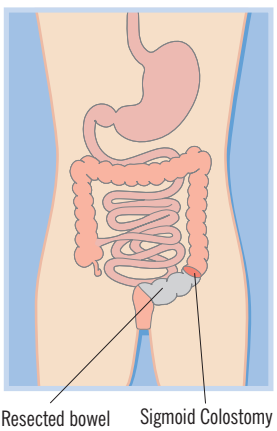
Appliance - Closed appliance - normally changed 1-3 times a day. A drainable pouch *may* be preferred if the output is consistently loose (e.g. Transverse Colostomy).

Operation	Description	Stoma Type	Stoma Reversible?	Notes
Abdominoperineal Excision of Rectum (APER)	Entire rectum and anus removed.	End Colostomy	No	Perineal wound.
Hartmann's procedure	Sigmoid colon removed. Rectal stump left in situ, proximal end oversewn.	End colostomy	Yes (usually)	Patient may experience loss of mucus from rectum.
Defunctioning Colostomy	+/- Resection according to site & nature of disease.	Loop or end colostomy	Yes (possibly)	May be performed to: - decompress bowel in colonic obstruction - bypass diseased bowel - protect distal anastamosis

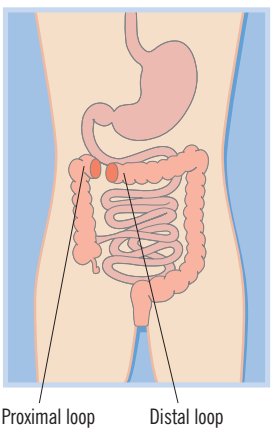
Abdominoperineal Excision of Rectum



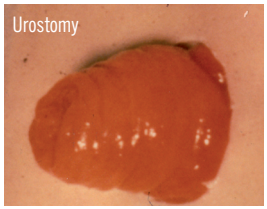
Hartmann's Procedure



Right Transverse Colostomy (Defunctioning)



Urostomy



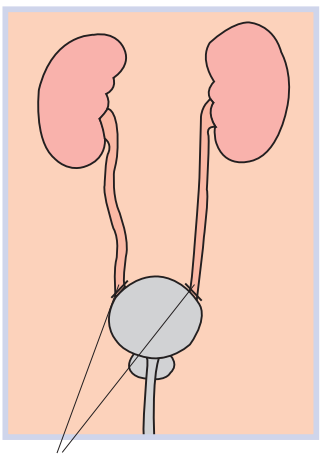
Normal output – continuous flow of urine. May contain some mucus.
! *Cloudy, offensive urine or increased mucus in urine may indicate urinary tract infection.*

Appliance – urostomy pouch with tap. Will require emptying several times in 24hrs. Pouch changed 1-3 days according to patient preference; a regular changing regime is advisable. Patient may prefer to attach continuous drainage bag at night.

Operation	Description	Stoma Type	Stoma Reversible?	Notes
Ileal Conduit	+/- cystectomy	Urostomy	No	

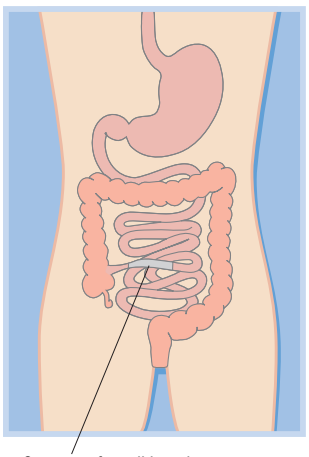
Urostomy – formation of ileal conduit

Stage 1



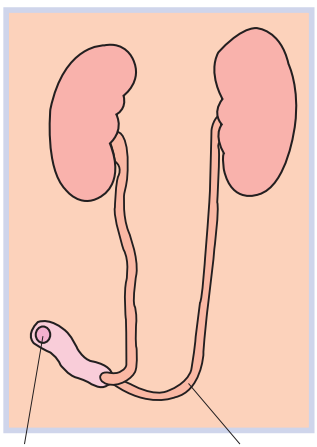
Ureters detached from bladder

Stage 2



Segment of small bowel detached to form ileal conduit

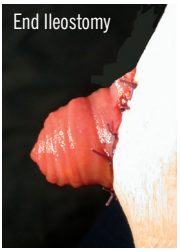
Stage 3



The ileal conduit opens on to the surface of the skin as the urostomy

The ureters are diverted from the bladder into the new ileal conduit

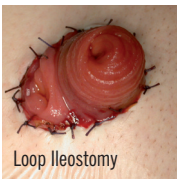
Ileostomy


End Ileostomy

Normal Output – fluid faeces. Consistency between "porridge" and watery and may vary throughout 24hours in normal patient.

Average volume between 500-700mls/24hrs.*

! ***Consistently watery output over 1litre/24hrs may lead to dehydration and electrolyte imbalance. Patient may report emptying very frequently or getting up several times at night to empty pouch. Particularly common in patients with loop ileostomy.*** *See Diarrhoea page 15.*

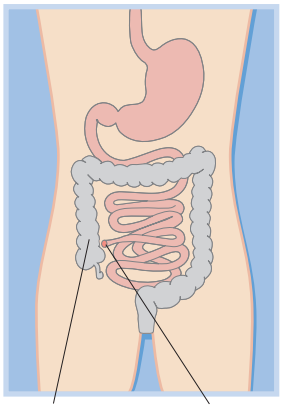

Loop Ileostomy

Appliance – Drainable – *pouch normally emptied 4-5 times in 24hrs. Pouch changed every 1-3 days, according to patient preference. A regular changing regime is advisable.

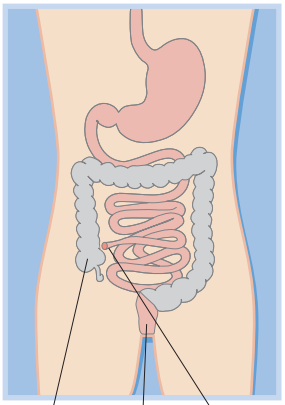
Operation	Description	Stoma Type	Stoma Reversible?	Notes
Panproctocolectomy	Removal of entire colon, rectum and anal canal.	End ileostomy	No	Perineal wound.
Total colectomy	Removal of entire colon. Rectum left in situ, proximal end oversewn or exteriorised as mucous fistula.	End ileostomy +/- mucous fistula	Yes	See care of mucous fistula. (Page 7).
Anterior Resection	Removal of upper part of rectum. Distal end of colon anastamosed to rectal stump.	Loop ileostomy	Yes	
Restorative Proctocolectomy (Ileoanal pouch formation)	Stage 1 – Total colectomy. Stage 2 – Removal of rectum, formation of ileal reservoir (pouch), anastamosed to anus + loop ileostomy. Stage 3 – Closure of ileostomy.	End ileostomy Loop ileostomy	Yes	Stages 1 & 2 may be combined in one procedure. Ileal pouch constructed from loops of small bowel.

Ileostomy

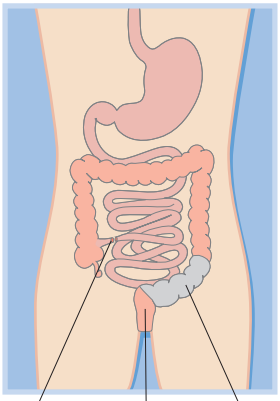
Panproctocolectomy



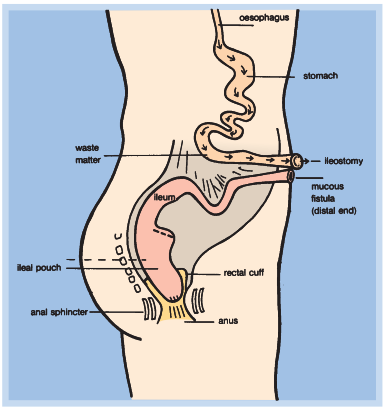
Total Colectomy



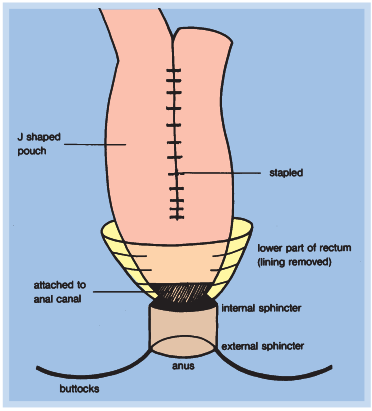
Anterior Resection with defunctioning ileostomy



Ileoanal pouch showing loop ileostomy



Structure of ileoanal pouch



Mucous Fistula

If primary anastomosis of the bowel is not possible, both ends of the bowel are brought out onto the surface of the skin as two stomas. The proximal end will pass faeces, the distal end mucus only – this is called a Mucous Fistula. (Occasionally the mucous fistula may pass retained faeces).

Initially the mucous fistula may pass a significant quantity of mucus, which will require a small or paediatric pouch to contain the discharge. After two weeks or so this discharge usually decreases, so that the patient can wear a stoma cap or other appropriate dressing. Seek advice from the Stoma Care Nurse.

Teaching Patient Self Care

Stoma patients will have many fears and anxieties relating to their stoma management on discharge from hospital. The community nurse is able to ensure patients receive continued practical care and support to suit their individual needs.

Preparation – Prepare equipment first

Basin or bowl of warm tap water

Disposal bag

Adhesive remover (e.g. Appeel)

Gauze swabs – to clean and dry skin

Barrier wipe – to protect skin

Prepared appliance (and clip if required)

Ostomy deodorant spray

Towel/cloth to protect clothing

- Ideal location – bathroom
- Plan timing of appliance change as part of routine hygiene needs where possible
- Encourage patient to wash hands
- Nurse guides or supervises patient according to patient's level of competence and confidence
- The amount of assistance required by the patient may vary at each stage of the procedure
- Encourage patient to think through each stage

Patient Action	Nurse Action	Rationale
Empty drainable pouch	Encourage to empty into toilet where possible.	To avoid spillage of contents when pouch removed.
Remove pouch	Encourage patient to remove pouch using adhesive remover around flange area of pouch.	To reduce trauma to skin and to make appliance change more acceptable to patient.
Clean and dry stoma & surrounding skin thoroughly	Observe patient technique.	Promoting good standards of skin hygiene will minimise risk of peristomal skin soreness and potential leakage of pouches.
Apply skin protection	Observe stoma & peristomal skin for any abnormalities or change in stoma size. May require new template to be cut – check stoma size with measuring guide. Pouch should fit snugly around stoma edges.	Protective wipe e.g. LBF helps to promote healthy skin and aids adhesion of pouch.
Apply pouch (One-piece pouch applied from bottom of the stoma upwards. Two piece appliance – flange placed over stoma & pouch attached)	Check appliance is stuck securely with no creases around flange. If drainable pouch ensure clip or tap are closed.	Prevent leakage and odour.
Dispose of pouch safely	Ensure patient is aware of how to dispose of soiled waste bag.	To ensure disposal of waste within guidelines of local policy.*

***NB** Where a colostomy patient uses flushable pouches, the outer cover of the pouch needs to be removed first and placed in the disposal bag.

Then proceed with removal of the pouch – both the inner liner and attached flange can be placed in the toilet and flushed away.

Nutritional Advice

The aim for a patient with a new stoma is to return to a normal, healthy diet as soon as possible.

The patient's appetite may initially be poor.

Some people may complain of a strange taste in their mouths; this will diminish with time.

The patient should:

Eat small regular meals. This is especially important to the Colostomist and Ileostomist as it will help the stoma to regulate itself.

Avoid skipping meals.

Avoid overeating – may cause wind, abdominal cramps and irregular motions.

Try to enjoy their food, relax, and take their time whilst eating.

If there are any concerns about the patient's nutritional needs, refer to the Community Dietician for advice and support.

Table 1 General Advice

Type of stoma	Advice
Colostomy A diet low in fibre may cause constipation. Passing a constipated stool can be painful.	**Eat regular meals** to allow stoma to regulate itself. **Prevent constipation** by increasing the amount of fruit and vegetables eaten. **Drink at least 2 litres** of fluid daily.
Ileostomy A diet high in fibre may cause excess flatus and faecal loss. High fibre foods may cause blockages/obstruction.	**Increase water and salt intake** to counteract loss via ileostomy, e.g. Dioralyte or home made hydration solution. (See page 15 for recipe.) **Take particular care with** – celery, dried fruit, nuts, coconut, mushrooms, oriental vegetables, potato skins, raw fruit skins, pips and stones, rhubarb, sweet corn, tomato skins. **If blockage occurs drink fluids to flush it through**. If this is unsuccessful patient will need to be admitted to hospital (see further advice page 15).
Urostomy To prevent urinary tract infections To reduce mucus production from stoma	**Drink plenty of water**, particularly in hot weather – 3 litres daily (Urostomy Association Guideline). **A daily glass of cranberry juice** (or tablets). **!** *Caution – cranberry juice may be contraindicated in patients on Warfarin, or with history of diabetes or gastric ulcers.*

Tables 2 to 7 highlight foods, which may cause problems to some stoma patients and possible foods and medication to resolve the problems.

It is important to remember these foods will not cause problems in all stoma patients.

Table 2

Foods which may *Cause* Odour

FOODS WHICH MAY CAUSE ODOUR •	COLOSTOMIST	ILEOSTOMIST	UROSTOMIST
Asparagus	•		•
Fish	•	•	•
Eggs		•	
Cabbage	•		
Onions	•	•	
Cheese		•	
Green Vegetables	•	•	
Baked Beans	•	•	
Cucumber		•	
Broccoli	•	•	

Table 3

Foods used to *Reduce* Odour

FOODS WHICH MAY REDUCE ODOUR •	COLOSTOMIST	ILEOSTOMIST	UROSTOMIST
Buttermilk	•	•	
Yoghurt	•	•	
Peppermint Oil	•	•	

Flatus

Nurse Action

- Assist patient to identify foods that cause wind. (see Table 4)
- Advise patient to
  - Eat regularly, do not miss meals
  - Eat slowly
  - Do not talk whilst eating
  - Avoid fizzy drinks
  - Avoid chewing gum
  - Avoid drinking through a straw

Table 4
Foods which may *Cause* Flatus

FOODS WHICH MAY CAUSE FLATUS •	COLOSTOMIST	ILEOSTOMIST
Green Vegetables	•	•
Fruit	•	•
Nuts	•	•
Peas	•	•
Cucumber		•
Beer		•
Onions	•	•
Sweet corn	•	•
Eggs	•	•
Beans	•	•
Fizzy drinks	•	•
Sprouts	•	•
Cabbage	•	•

Table 5
Foods used to *Reduce* Flatus

FOODS WHICH MAY REDUCE FLATUS •	COLOSTOMIST	ILEOSTOMIST
Buttermilk	•	•
Fennel Tea	•	
Natural Yoghurt	•	•
Peppermint Tea	•	

Liquid Output

Some foods may cause a liquid output in some patients, resulting in distress and embarrassment. Occasionally medication may be necessary to thicken the stool.

Nurse Action

- Give the patient relevant dietary advice. (Table 6 & 7)
- If necessary refer the patient to their local Stoma Nurse or GP for assessment. The Stoma Care Nurse will have access to thickening agents to place into the pouch.

Table 6
Foods which may *Cause* Liquid Output

FOODS WHICH MAY CAUSE A LIQUID OUTPUT •	COLOSTOMIST	ILEOSTOMIST
Highly spiced foods	•	•
Beans	•	•
Peas	•	•
Fruit	•	•
Chocolate		•
Prunes	•	•
Spinach	•	•
Fruit Juice	•	•
Lettuce		•
Fish		•
Nuts		•
Oily food		•
Onions		•

Table 7
Foods which may *Thicken* a Liquid Output

FOODS WHICH MAY THICKEN A LIQUID OUTPUT •	COLOSTOMIST	ILEOSTOMIST
Apple sauce	•	•
Bananas (ripe)	•	•
Cheese	•	•
Marshmallows	•	•
Milk (boiled)	•	
Noodles	•	
Peanut butter (smooth)	•	•
Plain boiled Rice	•	•
Tapioca	•	•
Potato	•	•
Pasta	•	•
Jelly	•	•

Constipation & Diarrhoea

Constipation
Constipation is the passing of hard stools, or a colostomy functioning less than two to three times a week.

Causes

Lifestyle	Pharmacological	Conditions	Obstruction
Lack of Fibre	Analgesia	Diabetes	Mechanical e.g. tumour
Lack of fluids	Antidepressants	Hypothyroidism	Diverticular disease
Inactivity	Iron	Hypercalcaemia	Adhesions
Foods that harden stools e.g. Cheese and Bananas	Antacids	Menstrual cycle	Functional
	Anticonvulsants	Multiple Sclerosis Paraplegia	

Type of stoma	Management
Colostomy	**Increase fibre intake** in diet. Advise five portions of fruit and vegetables a day. **Increase oral fluids** - water, squash or fruit juice e.g. orange. (Tea and coffee contain caffeine, which acts as a diuretic.) **Increase physical activity** if possible. **Two teaspoons of bran** added to food twice a day. **A daily mild aperient** may be necessary: - Bulking agents to increase faecal mass - Stimulants to increase peristalsis - Osmotic - Evacuant suppositories **!** ***If accompanied by pain and vomiting seek medical advice.***
Ileostomy An ileostomy cannot become constipated.	**!** ***If Ileostomy non-functioning for 12 hours - patient should seek medical advice***. (See advice re blockages page 15).
Urostomy can be prone to constipation for the first few weeks post-operatively, (due to small bowel resection to construct the stoma causing disturbance in bowel function).	**High fibre diet & daily aperient** until resolved.

Diarrhoea

Possible causes

- Dietary – certain foods,(see table 6 page 13)
- Side effect of medication
- Gastrointestinal infections
- Secondary to constipation
- Side effects of radiotherapy or chemotherapy.
- Extensive bowel resection

***Homemade Re-hydration Solution**

Dissolve half a teaspoon of salt and four teaspoons of sugar into 150mls of water.

Add 150mls of orange juice and mix.

Top up with a further 500mls of tap water.

(Garrow and James 1993.)

Action – *General*

- Establish the cause
- If gastrointestinal infection suspected, take stool sample to confirm an infective cause
- Ensure supply of drainable pouches (contact SCN if none available)
- Ensure adequate fluid intake maintained
- Stoma may become oedematous and swollen & bleed more easily. It may be necessary to increase the aperture of the pouch to fit. This swelling will resolve once the diarrhoea has settled

Colostomy

Cause	Action
Dietary	**Dietary advice** (see pages 10-13). +/- **Anti-diarrhoeal medication** e.g. Loperamide.
Secondary to Constipation	Treat with **appropriate laxatives**. **Educate regarding future prevention**. (See page 14).

Ileostomy

Need to be vigilant with maintaining adequate fluid intake as patient can become dehydrated very quickly.

Cause	Action
Dietary High output stomas (e.g. loop ileostomy)	**Increase fluid intake**. **Dietary advice** (see pages 10-13). **Maintain electrolyte balance**, electrolyte preparations e.g. Dioralyte may be advisable. +/- **Antidiarrhoeal medication**, e.g. Loperamide. Adjust dose as necessary. **Contact Stoma Care Nurse.**
Blockage/obstruction Symptoms – passing copious watery stool (may look like black tea), abdominal pain, possibly nausea or vomiting	**! *If vomiting, refer to GP or send to A&E.*** Otherwise – **clear fluids only for 24hrs**. **Maintain electrolyte balance** with electrolyte preparations e.g. Dioralyte or home made solution (see above).

Pancaking

Faeces gathers at the top instead of dropping down into the pouch. Occurs most commonly in patients with colostomies.

Occurs when there is little or no air in the pouch causing inside of pouch to stick together.

Faeces gathering at the top can force the pouch off the body.

Pancaking can be difficult to resolve, the following tips may help –

- Apply a filter cover over the filter to help keep flatus in the pouch
- Apply a lubricating jelly such as Vaseline or baby lotion to the inside of the pouch
- Place a scrunched up swab or toilet tissue inside the pouch

If the above does not help refer to the stoma care nurse.

Mucous Discharge per Rectum

A patient who has retained their rectum and anal canal may have the feeling that they need to pass motion rectally, because the bowel still produces mucus.

Management

- Reassure the patient
- Advise patient go to the toilet, avoiding straining
- Rectal administration of a glycerine suppository may help but seek advice from Stoma Care Nurse prior to administration

  ! *Caution – rectal suppositories should not be administered if patient has a low rectal anastamosis e.g. Anterior Resection*
- Pads may be required to protect clothing
- Maintain good perianal hygiene
- Use of barrier creams to protect anal area

Problem Solving

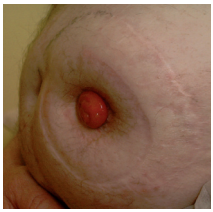
The following guidance may help in identifying and managing some common problems.

! *Problems which do not resolve within a few days should be referred to the Stoma Care Nurse for further advice.*

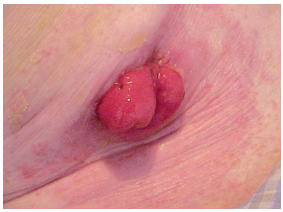
Pouch Leakage

Cause	Management	Additional Advice
Pouch aperture too large[1]	**Measure stoma** with measuring guide. **Cut pouch to fit snugly** around stoma. **Supply template** for patient to cut accurately/or cut sufficient supply if patient unable to manage this.	Stoma size normally shrinks during first 8 weeks post-operatively. Size should be monitored regularly during this period. Once size stabilised, pouches may be cut by delivery service – contact Stoma Care Nurse to arrange.
Skin Crease or 'Moat' [2]	**Apply filler paste** e.g. Dansac Soft Paste to crease.	Contact Stoma Care Nurse for product advice
Badly applied pouch (e.g. creases in adhesive)	**Observe/revise patient's technique.**	When applying pouch: – abdominal skin should be gently stretched to flatten out skin folds – align pouch below stoma first – try alternative positions (standing/ sitting) to obtain optimum view.
Flat/retracted stoma	**Refer to Stoma Care Nurse** for assessment of appliance	As stoma shrinks post-operatively, stoma may become flatter. Leakage problems more likely if output fluid.
Skin moist	**Ensure skin dry** before pouch applied. **Avoid use of creams or talc** under flange.	Excessive use of products such as Orahesive powder/Orabase paste impair pouch adhesion. These products should be used sparingly.
Pouch overfilling	**Establish routine** for emptying & changing. **Assess stoma function.** **Urostomy – review night drainage.**	See section on Diarrhoea (page 15).

[2] Recessed stoma showing peristomal 'moat'



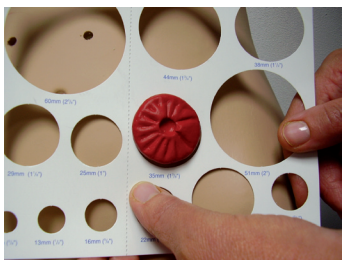
[2] Stoma sited in skin crease



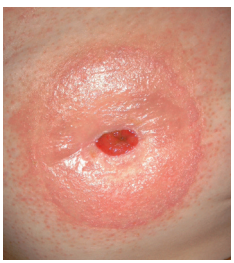
Sore Skin

Cause	Identifying features	Management
Pouch aperture too large[1]	Red/excoriated skin immediately around stoma.	**Measure stoma** with measuring guide. **Cut pouch to fit snugly** around stoma. **Supply template** for patient to cut accurately. *(NB pouches may be cut by delivery service – **contact Stoma Care Nurse** to arrange).*
Pouch left on too long (especially Ileostomy & Urostomy)	Pouch adhesive eroded (check back of flange on removal).	**Change pouch more often** (e.g. 48 hourly for drainable pouch). *If skin weeping,* **apply *Orahesive*** powder *sparingly* until healed (excessive use will prevent appliance sticking).
Corrosive output	Ileostomy – excessive watery effluent. Colostomy – diarrhoea. Urostomy – ? UTI.	**Assess stoma function** (see section on diarrhoea page 15). **Refer to Stoma Care Nurse**.
Sensitivity to adhesive[2]	Red/itchy skin – showing shape of flange.	**Mild symptoms – alchohol-free skin barrier** preparation (*e.g.* ***LBF***). **Moderate/Severe symptoms – refer to Stoma Care Nurse** for assessment. *A hydrocolloid wafer may be used under the flange as a temporary protective measure.*

[1] **Using measuring guide to enable accurate cutting of stoma pouch**



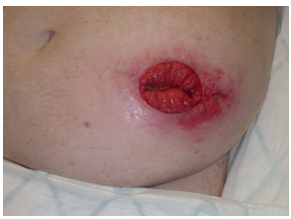
[2] **Contact dermatitis caused by sensitivity to flange adhesive**



Sore Skin

Cause	Identifying features	Management
Leakage[3]	Irregular patch of red/excoriated skin at site of leak.	See page 17 for causes and management.
Trauma	– ? frequent excessive changing (> 3x/24hrs) – poor technique	**Observe technique**, modify as appropriate. Excessive changing may be related to overactive stoma, or psychological issues. **Refer to Stoma Care Nurse** for assessment. **Use adhesive remover** (*e.g.* ***Appeel***) to aid pouch removal. **Shave peristomal hair** weekly.
Pre-existing skin condition eg. psoriasis, eczema	Scaly, red, itchy skin.	**Refer to Stoma Care Nurse** for assessment and advice.
Fungal infection – (associated with leakage, sweating, antibiotic or immuno-suppression therapy).	Macular/papular rash with erythema.	**Swab skin.** **Antifungal powder or cream**. May need additional accessories to prevent leakage during treatment – **refer to Stoma Care Nurse**.

[3] **Excoriated skin due to leakage**

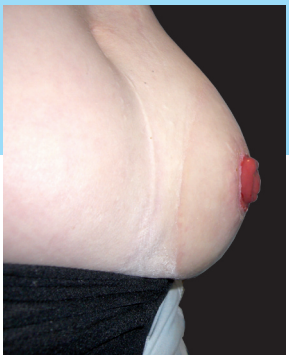


Stoma Complications

Refer to your Stoma Care Nurse for assessment and management of each of these complications.

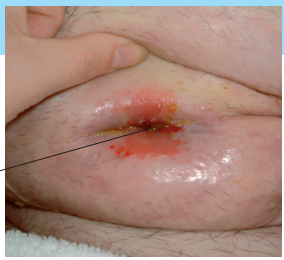
PARASTOMAL HERNIATION

Definition	Symptoms/Patient Problems	Management
A protrusion of an abnormal amount of intestine in the tissues surrounding a stoma. May occur with any type of stoma Can vary greatly in size and shape. Age and poor muscle tone may cause the hernia to be larger.	▶ Patient may experience a dull ache on the affected side ▶ Regular episodes of constipation /diarrhoea. ▶ Difficulties fitting an appliance as hernia increases in size ▶ May develop issues with body image. ▶ Parastomal hernias may become strangulated.	▶ Early assessment by a Stoma Care Nurse for alternative appliances and/or support garment ▶ Surgical correction – not always successful



STENOSIS

Definition	Symptoms/Patient Problems	Management
Narrowing of the lumen of the stoma.	▶ Stools passed appear 'ribbon-like' in the Colostomist ▶ May present as reduced output or partial obstruction in the Ileostomis ▶ Patients may experience cramps as stools are passed and/or painful explosive flatulence	▶ Keep stools soft to aid easy expulsion from the stoma ▶ Early assessment by the Stoma Care Nurse ▶ Dilation or further surgery to refashion the stoma



PROLAPSE

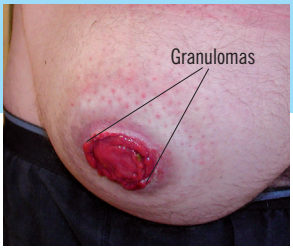
Definition	Symptoms/Patient Problems	Management
Length of intestine pushed out through the stoma. May occur in any type of stoma More common in Loop-Transverse Colostomies	▶ Enlarged, possibly oedematous, stoma ▶ Difficulties fitting pouch ▶ Anxiety at stoma appearance (as long as the stoma appears pink and healthy, prolapse is not necessarily a serious problem)	▶ Advice about suitable appliances from the Stoma Care Nurse ▶ Surgery may be indicated ▶ **!** *If stoma dark, non-functioning or painful seek urgent medical advice*

RETRACTION

Definition	Symptoms/Patient Problems	Management
Stoma no longer lies on the abdominal wall, appears sunken or in a dip. Causes include: Weight gain If the stoma is brought to the surface under tension during surgery	▶ Leakage of effluent onto peristomal skin ▶ Sore skin ▶ Difficulties with pouch adherence	▶ Refer to Stoma Care Nurse for advice on appropriate appliances and accessories

GRANULOMA

Definition	Symptoms/Patient Problems	Management
Over-granulation. The tissue surrounding the stoma appears raised, red and lumpy. May occur following trauma, recent healing of the muco-cutaneous junction, chronic exposure of skin to stoma effluent.	▶ Granulomas often bleed profusely when touched	▶ Early referral to the Stoma Care Nurse ▶ Excessive coverage by granulomas may require surgery.



Common side effects of Chemotherapy and Radiotherapy

Fatigue

Can occur in patients undergoing chemotherapy or radiotherapy. Patients may need support with aspects of daily living.

Gastrointestinal disturbances

Nausea, Diarrhoea, Abdominal Pain, Constipation.

- Nausea – patients who receive a treatment that is known to cause nausea should be given anti-emetics to take regularly
  - ensure adequate nutritional intake maintained
  - If vomiting, monitor to ensure hydration maintained. Ileostomists can become dehydrated quickly
- Diarrhoea (see advice page 15)
  - Ileostomists may find their output looser if they do not eat regularly, little but often is best
  - maintain adequate diet and fluid intake. A low residue, high protein, high-calorie diet can be helpful
  - Loperamide may help reduce the diarrhoea. Imodium suspension may be more appropriate as this will be absorbed more quickly
  - Colostomists may require drainable pouches
  - Ileostomists will need close monitoring in order to avoid dehydration and should be made aware of the signs

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