



STOMAL COMPLICATIONS

<u>Condition</u>	<u>Information</u>	<u>Cause</u>	<u>Management</u>
Constipation	<p>-Constipation only applies to colostomists.</p> <p>-Failure of an ileostomy to function would usually be due to an obstruction (See Obstruction)</p>	<p>Causes of constipation are the same for a person with no stoma, i.e. Diet, inadequate fluid intake, immobility, drugs (analgesics)</p>	<p>-Establish cause of constipation and treat accordingly.</p> <p>-Laxatives should always be prescribed to counteract the effect of analgesics.</p> <p>-The introduction of any suppositories/enemas via a colostomy should always be preceded by careful digital examination to establish the direction of the colon.</p>
Obstruction	<p>May occur in both ileostomy and colostomy.</p> <p>An obstructed ileostomy will either have no output, or sporadic high volumes of watery faecal fluid. The patient may complain of cramping pains.</p>	<p><u>Colostomy</u> – due to constipation, recurrence of disease, adhesions or stricture.</p> <p><u>Ileostomy</u> – due to recurrence of disease, adhesions, stricture, food blockage.</p>	<p>-Food blockage – advise the patient to drink plenty of water to help flush the blockage through, and apply a warm compress over the stoma site. If the blockage does not resolve within 24hrs patient should present at Emergency.</p> <p>-Establish cause of blockage and refer/treat accordingly.</p> <p>-Dietary advice re: foods that cause blockages i.e. Nuts, sweet corn, popcorn</p>
Diarrhoea	<p><u>Colostomy</u> – if a patient is using a closed bag (non-drainable) recommend the use of a drainable bag until the diarrhoea settles, this will prevent skin irritation and possible breakdown.</p> <p><u>Ileostomy</u> – are at high risk of becoming dehydrated (See Dehydration).</p>	<p>May be caused by diet, drugs (antibiotics), gastrointestinal upset, emotional upset, disease, adjuvant therapy, malabsorption and electrolyte imbalance (specifically pertinent to ileostomies)</p>	<p>-Anti-diarrhoeals, which reduce motility, may be used eg. Loperamide. Take 30-45mins prior to meal times.</p> <p>Ileostomists may need to take Loperamide permanently to control their stoma output. (Ideal ileostomy output consistency should be “porridge-like”)</p> <p>-Establish the cause and treat accordingly.</p>

STOMAL COMPLICATIONS

<u>Condition</u>	<u>Information</u>	<u>Cause</u>	<u>Management</u>
Dehydration	Ileostomy patients are at high risk of becoming dehydrated due to their loose, sometimes watery output. Ileostomists are more likely to become dry on hot days, or when exercising.	High stomal losses due to malabsorption, gastrointestinal upset, emotional upset, diet, drugs (antibiotics), disease, adjuvant therapy.	-Advise salt be added to cooking and meals, eat salted chips, etc. -Advise to drink plenty, unless the patient is being treated for intestinal failure/small bowel syndrome – these patients will need to limit their “normal” fluid intake, and drink high salt electrolyte drinks. -Administer Loperamide and/or Codeine Phosphate to control and slow the stoma output – refer to STN for recommended starting doses. -Advise re-hydration electrolyte drinks to replace lost salts.
Retraction	May occur in ileostomy, colostomy and/or urostomy.	May occur through weight gain, necrosed tissue causing the bowel to slough away leaving viable bowel beneath the abdominal wall or if the bowel is under tension.	-A convexed appliance will be needed and/or stomahesive seals to manage the retracted stoma. -Refer to STN for review. -Possible need for refashioning of stoma if unable to manage using available stomal appliances.
Flush stoma	Ileostomy – should ideally be spouted to allow easy management, and reduce the risk of leakages. Colostomy – most colostomies are flush, this is the expected outcome.	A flush ileostomy may be due to surgical technique, the bowel may be under tension, or post-operative necrosed tissue causing the bowel to slough away leaving the stoma less spouted.	-A flush ileostomy will need stomahesive seals and/or convexity appliances to reduce leakages and manage effectively. -Refer to STN for review.




STOMAL COMPLICATIONS

<u>Condition</u>	<u>Information</u>	<u>Cause</u>	<u>Management</u>
<p><u>Bleeding</u></p> <p>Mechanical trauma</p>	<p>Some bleeding on the edge of the stoma is normal.</p> <p>Bleeding from inside the stoma – refer to Colo-rectal Out-patient clinic asap.</p>	<p>Aggressive cleaning may cause slight bleeding.</p> <p>Poor technique – an inadequately sized pouch/wafer hole can cause stomal laceration by rubbing.</p>	<p>Avoid vigorous rubbing.</p> <p>Observe stoma & hole, check for laceration/ulcers.</p> <p>Check size of template/hole cut. Allow for 2mm gap. Resize template.</p>
<p><u>Bleeding</u></p> <p>Granulomas</p>		<p>Reactive tissue composed of histocytes, occurring in response to presence of a foreign body e.g. suture material or other irritant.</p> <p>Friable, tendency to recur and easily bleeds.</p>	<p>Check position of granulomas – stomal mucosa or mucocutaneous junction.</p> <p>Chemical diathermy (AgNo3 – Silver Nitrate).</p> <p>Remove any irritant e.g. resize template if aperture size too large.</p> <p>Detect and remove existing undissolved suture material.</p> <p>Surgical review/revision if large or extensive.</p> <p>Surgical/Oncology review if lesion/s arouse suspicion of malignancy.</p>
<p><u>Bleeding</u></p> <p>Peristomal Varices</p>	<p>Stoma likely to be surrounded by a caput medusae of dilated cutaneous veins.</p> <p>Variceal bleeding can be profuse and recurrent.</p> 	<p>Hepatic cirrhosis.</p> <p>Liver metastases.</p> <p>Portal hypertension.</p>	<p>Observe stoma and peristomal skin appearance.</p> <p>Note patient's report of any excessive bleeding</p> <p>Observe area of bleed and amount.</p> <p>Silver Nitrate (AgNo3) if minor irritation.</p> <p>Avoid trauma to area.</p> <p>Ensure no rubbing on mucocutaneous edge.</p> <p>Trial two piece system or one piece drainable to avoid repeated removal trauma.</p> <p>Apply direct pressure to any active bleed.</p> <p>Direct to an Emergency Department if risk of hypotensive state.</p> <p>Surgical/Medical review.</p>

STOMAL COMPLICATIONS

<u>Condition</u>	<u>Information</u>	<u>Cause</u>	<u>Management</u>
<p><u>Bleeding</u></p> <p>Chemotherapy / Radiotherapy</p>		<p>Stoma mucosa may be temporarily affected by chemotherapeutic agent and if located in the radiation treatment, the stoma may be susceptible to damage e.g.bleeding.</p>	<p>Use gentle stomal cleansing/hygiene technique.</p> <p>Avoid trauma by careful application and appropriate stomal aperture.</p> <p>Avoid digital examination of the stoma.</p> <p>Pectin/gelatin compound protective powder to mucosa.</p> <p>If superimposed infection e.g. Candidiasis detected or inflammation/infection at the mucocutaneous junction, provide skin protection and/or systemic therapy.</p> <p>Avoid stomal irrigation.</p>
<p><u>Bleeding</u></p> <p>Malignancy</p>	<p>Recurrent malignancy at the stoma site is rare.</p>	<p>Present with discoloured skin, bleeding and a suspicious lesion.</p>	<p>Biopsy.</p> <p>Surgical review.</p> <p>Possible wide excision of abdominal wall and re-siting of the stoma.</p>
<p><u>Bleeding</u></p> <p>Proximal Gastrointestinal</p>	<p>Bleeding from stomal lumen.</p>	<p>Exacerbation of inflammatory bowel disease.</p> <p>Varices</p>	<p>Review medications e.g. steroids, anticoagulants.</p> <p>Medical/Surgical review.</p>

STOMAL COMPLICATIONS

<u>Condition</u>	<u>Information</u>	<u>Cause</u>	<u>Management</u>
<p>Parastomal hernia</p> 	<p>May develop weeks or years after surgery. Incidence around colostomy greater than ileostomy or urostomy. Symptoms: dull ache or dragging sensation. Appliance problem related to difficulty with adherence due to presence of bulge</p>	<p>Result from a weakness in abdominal wall</p>	<p>Review by STN. Support belt or support pants. Acute pain, nausea or vomiting, discolouration to stoma requires immediate attention as this may indicate the bowel is strangulated. Surgical correction may be necessary.</p>
<p>Prolapse</p> 	<p>A length of bowel prolapses or telescopes out onto the surface of the abdomen</p> <p>Colostomies, especially tranverse, prolapses are more common than ileostomy or urostomy</p>	<p>Formation of an overly large aperture for the stoma at time of surgery. Stoma positioned outside the rectus muscle. Bowel poorly fixed to abdominal wall. Increase in intra-abdominal pressure. Obesity.</p>	<p>Review by STN initially, then Surgeon. Severity of prolapse is assessed to determine any evidence of ischaemia. If stoma can be reduced the patient may then wear an abdominal binder or support pants for comfort. To reduce prolapse, lie the patient down, and with a well lubricated hand and gentle rocking motion massage the bowel. The application of a cold towel or sugar applied directly to area of prolapse may reduce oedema and facilitate reduction. Surgical correction is immediate for any evidence of ishaemia.</p>
<p>Stenosis</p> 	<p>The stomal opening becomes narrowed and may be almost closed. Symptoms: Urostomy: loin pain, offensive urine, recurrent UTIs Colostomy/Ileostomy: pain when passing stool, thin "ribbon-like" stool, abdominal pain or cramps</p>	<p>May be the result of stomal complications such as retraction, or formation of excessive scar tissue</p>	<p>Review by STN Urostomy: prompt investigation to assess urinary tract All stomas: gentle dilation using a well lubricated finger. Dietary advice and possibly stool softeners. Eventual surgical intervention is usually necessary to refashion stoma</p>