The G.I. Ostomies

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GENERAL INFORMATION:
Definitions:

- **Ostomy**- (“Os” means mouth or opening + “tomy” means surgical cutting). An ostomy is a surgically creating opening. The ostomy surgery connects a hollow organ on the inside (like the intestine) to the outside of the body through the skin.

- **Peristomal** - the area around the stoma

- **Pouch**- the bag used to collect body fluids such as stool from an ostomy.

- **Stoma**- mouth-like opening that can be seen at the skin level.

- **WOC nurse**- wound, ostomy & continence nurse a.k.a. stoma nurse, ostomy nurse, enterostomal (E.T.) nurse or therapist
General Ostomy Facts:

• **Purpose: (4 D’s)** -
  - **Divert** - reroute from damaged/diseased area in order to allow that part to rest and heal.
  - **Decompress** - to relieve pressure from an obstruction or excess air.
  - **Drain** - outlet for fluids to move out of the body.
  - **Deliver** - access for the administration of formula, fluids and/or medications.

• Basically a way to get something **IN** or get something **OUT**

• **Other facts:**
  - Ostomies help patients live and improve their QOL.
  - Can be temporary or permanent depending on patient’s condition.
  - Location is based on where the problem is and the name reflects this location.
  - Some patients have more than one ostomy.
  - Some ostomies require a tube. Those that don’t usually require a pouch to contain fluids which can be very irritating to the skin.
GI Ostomies:

- **Gastrostomy**: opening into the stomach.
- **Jejunostomy**: opening into the jejunum
- **Cecostomy**: opening into the cecum; AKA ACE: (Antegrade Colonic Enema); M.A.C.E. (Malone Colonic Enema); appendico-cecostomy.
- **Ileostomy**: opening into the ileum; AKA fecal diversion.
- **Colostomy**: opening into the colon; AKA fecal diversion.
- **Mucous Fistula** - the second of two stomas or the second opening in a single loop ostomy stoma. It may discharge some mucous. Also called the non-functioning stoma.
## Ostomy Comparison:

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<th>Ostomy</th>
<th>Purpose</th>
<th>Type of DX</th>
<th>Output</th>
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| **Gastrostomy** | Sometimes done w/ Nissen  
Administering feedings, fluids, meds; decompression | FTT, Neuro-devestated, CP, Cranio-facial, Aspiration, CF, DI               | Acidic, clear; tube usually required                              | GS, GI, IR           |
| **Jejunostomy** | Administering feedings-bypass stomach                                    | Gastropareis, aspiration                                                  | Alkaline, potential for highest output, very caustic, water, green; tube usually required | GS, GI, IR           |
| **Cecostomy** | Administering fluids/laxatives                                          | Spina bifida, Encopresis, h/o impactions, paralysis                      | Alkaline, Liquid, brown, tube usually required                    | GS,GI,IR,UR          |
| **Ileostomy** | Diversion to allow colon to heal after surgery; scope access for intestinal transplant | IBD (u.c.), FAP, NEC, gastroschesis, pseudo-obstr, total colonic HD, intestinal transplant | Alkaline, High output, Very caustic; liquid to pasty; requires a pouch | GS                   |
| **Colostomy** | Diversion to allow colon to heal after surgery, end point               | HD, Imperforate anus, colon ca, trauma                                    | liquid/pasty to firm - depends on the section removed; doesn’t always require a pouch | GS                   |

*GS: general surgery; IR: Interventional radiology; UR: urology*
Ostomy Surgery:

BEFORE & AFTER
Before Surgery:

- Education is very important
  - Staff: WOC nurses; Child Life Specialists
  - All care takers should be present when education is done
  - Resources: Web sites
- Support is essential for a good outcome
  - Psych
  - Support group
  - Visit from an ostomate
- Involve the patient as much as possible
- It can take parent/patient a while to agree to surgery
Resistance to Surgery: The Reasons

INVASIVE  Cultural
Body image  FEAR
Alone  Disgust
GRIEF  Financial
Failure
After surgery:

- **Education:**
  - WOC nurses, GI/Surgery staff, Patient educators
  - **All** care takers should be present for teaching

- **Case Management**
  - supplies
  - home care

- **Special Considerations:**
  - Gastrostomy/cecostomy- primary tube: needs stabilization/minimal manipulation
  - Ileostomy/Colostomy: stoma will shrink and change shape over 6 weeks, First 2-3 days bloody drainage

- **Follow-up:**
  - post-op check
  - tube change out when applicable
THE STOMA & PERISTOMAL SKIN
Assessment:

- History:
  - Stoma
    - When was the stoma created?
    - What is the function of the stoma? (don’t assume)
  - Problems:
    - Pain, itching, redness, discharge, odor, etc
  - Daily care:
    - Skin regimen
    - Treatments: past/current & response; technique
  - Pertinent history:
    - Change in meds, recent illness, etc
  - Device info

- Exam:
  - Stoma:
    - Color, shape, protrusion, bleeding, drainage
  - Peristomal skin:
    - Intact?, color, lesions, swelling, drainage
  - Device (if applicable):
    - Fit of tube/pouch, Stabilization of tubes
Stoma Facts:

• Bowel stomas should be red like the inside of your mouth, and they should be moist and soft.
• Stomas might bleed a little when rubbed or touched.
• They don't hurt when touched because there are no nerve endings.
What’s Not So Normal?

- **Surgical:**
  - Wound dehiscence; infection

- **Skin:**
  - Irritation, skin breakdown, infection, fungal rash, granulation tissue, leakage of intestinal fluids

- **Stoma:**
  - Swelling, prolapse, retraction, herniation, stenosis

- **Output:**
  - **Too Much:** can cause skin breakdown; can lead to dehydration
  - **Too Little:** caused by obstruction, impaction or stricture
Gastrostomy Abnormalities:
G/J Abnormalities:
Ileostomy Abnormalities:
Skin Care:

• **Clean/Dry:**
  - Clean with mild products
    - only use anti-bacterial products if ID recommends
    - water only for ostomy
  - Gently dry:
    - soft cloth
    - reduce friction by using a squirt bottle

• **Treat:**
  - Correct the cause:
    - Remove irritants
    - Change/stabilize tube
  - Heal skin
    - Medications: steroid cream, anti-fungal, barrier powder

• **Protect:**
  - Absorb fluids:
    - powder, cholestyramine, dressings
  - Protect skin from drainage-(caustic depending on type of fluid and duration of exposure). Use barrier products.
    - Non-pouched stoma: Blot off drainage and reapply product
    - Pouched stomas; reapply with pouch changes- some products cause pouch not to adhere
      - less is more unless there’s an issue
  - Protect site from trauma and accidental removal:
    - binder, ace wrap, clothing, etc
Building a Barrier:

- **Purpose:**
  - Protects the skin from caustic fluids and helps the skin heal

- **Products**¹:
  - Intact skin – zinc oxide, petrolatum, skin prep
  - Non-intact skin – add barrier powder

- **Technique:** (as important as the products):
  - Put medications on first
  - If using powder apply before barrier creams/sprays (dust off excess; don’t let powder extend past borders of adhesive of pouch)
  - Skin prep/film helps seal in powder and provides a light barrier
  - Apply creams as the top layer–apply thick like icing
  - Layer products if needed
  - Don’t wipe products completely off each time, blot soiled areas and reapply products

¹do not use ointment/Creams when pouching
PROBLEMS AND CHALLENGES
The challenges:

• Anatomic:
  ◦ Small belly-small surface
  ◦ Multiple stomas or devices on abd
  ◦ Skin folds, creases and scars

• Accessibility:
  ◦ Products- not available or insurance won’t pay
  ◦ Location of patient to services/resources needed

• Patient/Caretaker:
  ◦ Compliance of patient/family
  ◦ Literacy levels and motivation to learn
  ◦ Change in care takers

• Treatment:
  • Unresponsive to treatments
Red Flags:

Output:
- High output: Dehydration (esp. jejunostomy/ileostomy)
- Decreased or no output from ileostomy
- No bowel movement w/increased abdominal distention - cecostomy
- Vomiting feces and/or blood

Stoma:
- Color: black, dusky, pale, gray, brown
- Prolapsed with bleeding

Site/abdomen:
- Signs of infection esp during the first 2 weeks post-op
  - Moderate to severe redness, swelling and/or pain around the stoma especially if worsening.
- Abdominal rigidness/tenderness

Feedings:
- Formula in mouth and/or choking; upper airway noises during or after feeding
- Pain and/or vomiting during or right after feedings, especially if recurring.
- Broken or obstructed tube esp if not able to give feedings/meds
- Signs of dumping syndrome (esp. with J feeds)
  - Nausea/Vomiting, sweating, heart palpitations, rapid heart rate, weakness, fatigue, passing out; dizziness, lightheadedness, shakiness, feelings of anxiety, nervousness

Other:
- Any worsening symptom especially if the patient has a fever.
ONLINE RESOURCES
General:
- American Pediatric Surgical Nurses Association www.apsna.org
- Wound, Ostomy & Continence Nurses Society www.wocn.org

Gastrostomy:
- AMT www.amtionovation.com
- Feeding Tube Awareness www.feedingtubeawareness.org
- Complex child www.complexchild.com
- Kimberly-Clark www.mickey.com
  - www.youtube.com/user/mymickeytube
- The Oley Foundation www.oley.org
- Special Child www.specialchild.com

Ostomy:
- Coloplast www.coloplast.com
- Convatec www.convatec.com
- Crohn’s and Colitis Foundation www.ccfa.org
- Friends of Ostomates www.fowusa.org
- Hollister www.hollister.com
- The J-Pouch Group www.jpauch.org
- Pull Through Network www.pullthrough.org
- Quality of Life Association www.qla-ostomy.org
- United Ostomy Association of America www.uoaa.org
- Youth Rally http://rally4youth.org/