A Practical Guide to Stomas for Healthcare Professionals

The purpose of this guide is to provide healthcare professionals with the background knowledge and skills to care for and support patients with a newly formed stoma.

Version	2.0 Updates include: • Rebadging with HWE ICB and removal of HVCCG headers • Review date removed and replaced with standard statement.
Approved by	Medicines Optimisation Clinical Leads Group
Date approved/updated	Approved October 2021, updated December 2023
Review date	The recommendation is based upon the evidence available at the time of publication. This recommendation will be reviewed upon request in the light of new evidence becoming available.
Superseded Version	v1.0

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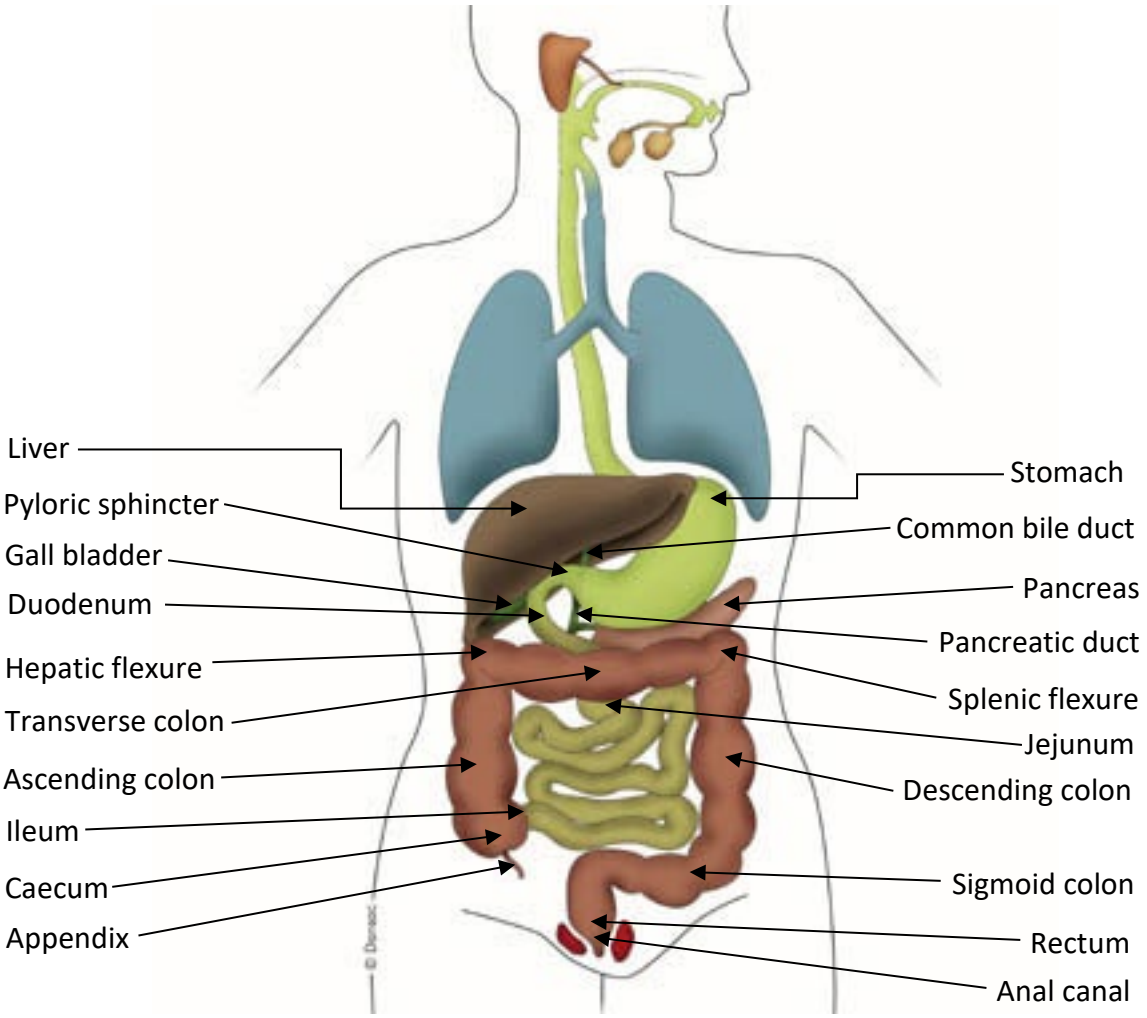
Anatomy and Physiology of the Digestive System



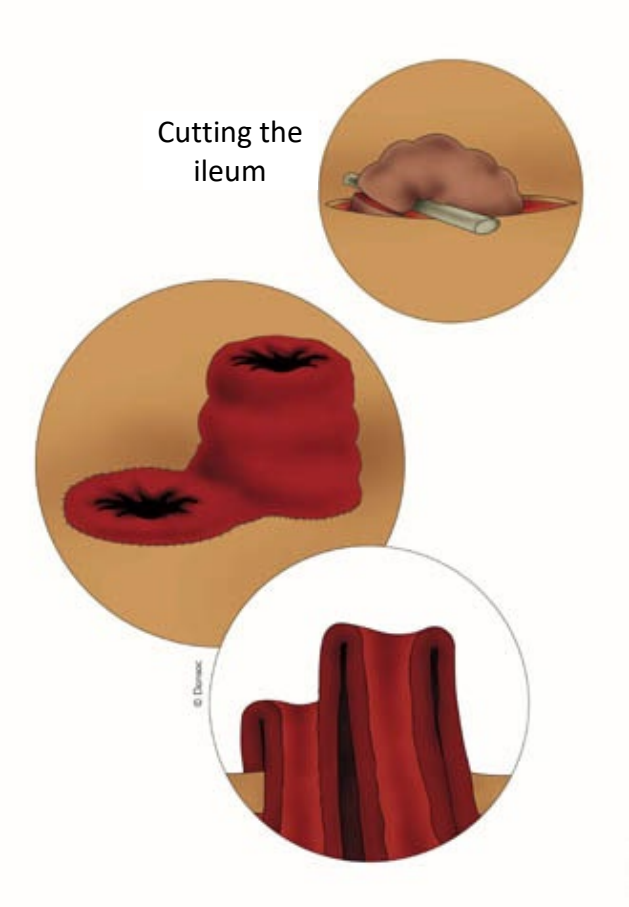
Types of Stomas and their Position

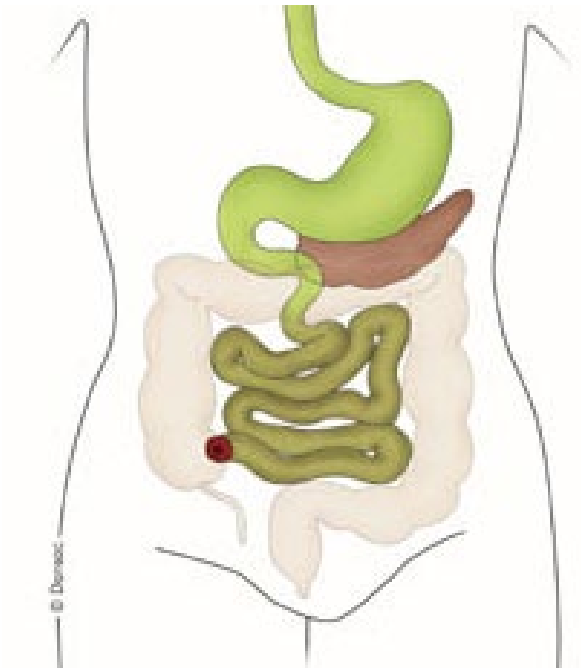
Types of Stoma	Position
End ileostomy (terminal ileum)	Right iliac fossa
Loop ileostomy (terminal ileum)	Right iliac fossa
Ileo-conduit (urostomy) (terminal ileum)	Right iliac fossa
Transverse loop colostomy (hepatic flexure / large bowel)	Right Upper quadrant
End colostomy (sigmoid colon / large bowel)	Left iliac fossa
Loop colostomy (sigmoid colon / large bowel)	Anywhere on the left side of bowel (descending bowel & sigmoid)

Reasons for Stoma Formation

- Colorectal cancer (cancer of the large bowel & rectum)
- Diverticulitis
- Ulcerative Colitis
- Crohn's Disease
- Bladder Cancer
- Congenital Abnormalities (normally involving paediatrics)
- Trauma
- Fistulae
- Gynaecological cancer
- To bypass a rectal or pelvic wound
- To bypass an obstructing colorectal cancer - palliative procedure
- Poor circulation to bowel post cardiac surgery or a cardiac event

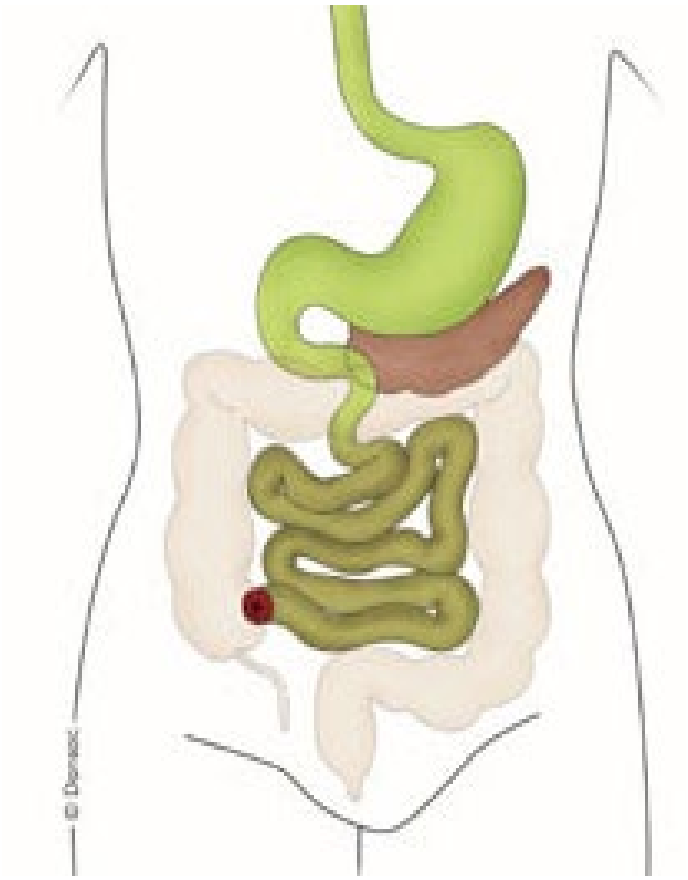
Loop Ileostomy





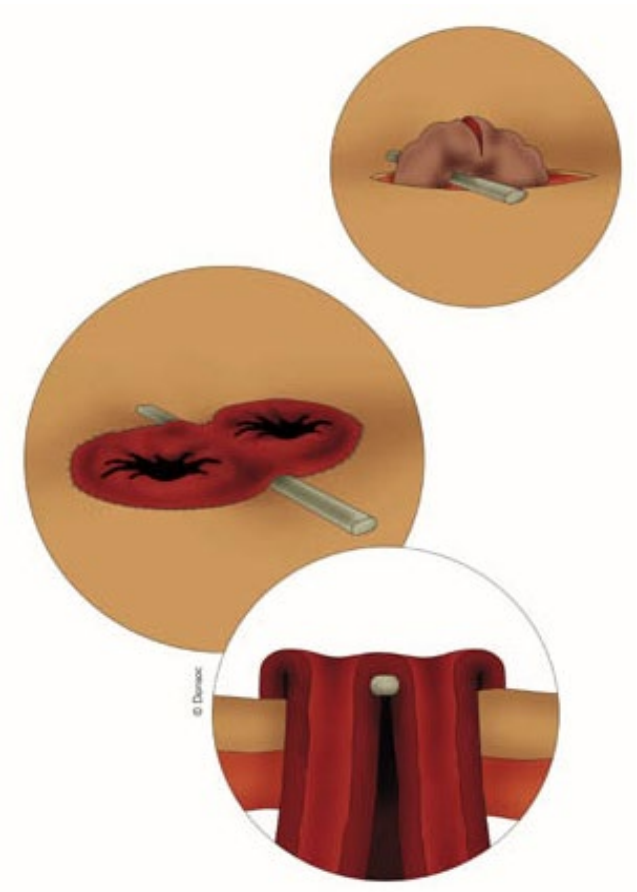
The loop Ileostomy is a stoma brought to the surface of the abdomen to protect the bowel anastomosis (surgical join). It is mainly a temporary stoma. It has a proximal (spouted) lumen (where the stool comes out) and a distal (flush) lumen, the redundant part of the loop that goes back to the rest of the bowel continuity.

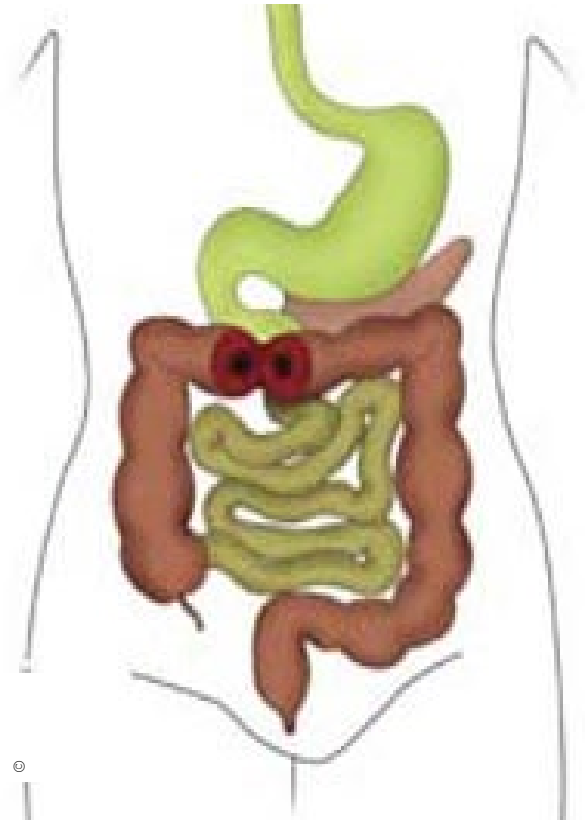
End Ileostomy



The end Ileostomy is mainly a permanent stoma from the small bowel. The stoma is swollen due to its post-op nature, it will shrink over the next 2-4 weeks. The stoma is red in colour which is normal as it has a rich blood supply. It is normal for a stoma to bleed slightly when it is cleaned. There are no sensory feelings within the stomas as there are no sensory nerve endings in the bowel. Liquid stool of between 500-800mls per day will come away from the stoma and a drainable bag is worn over it.

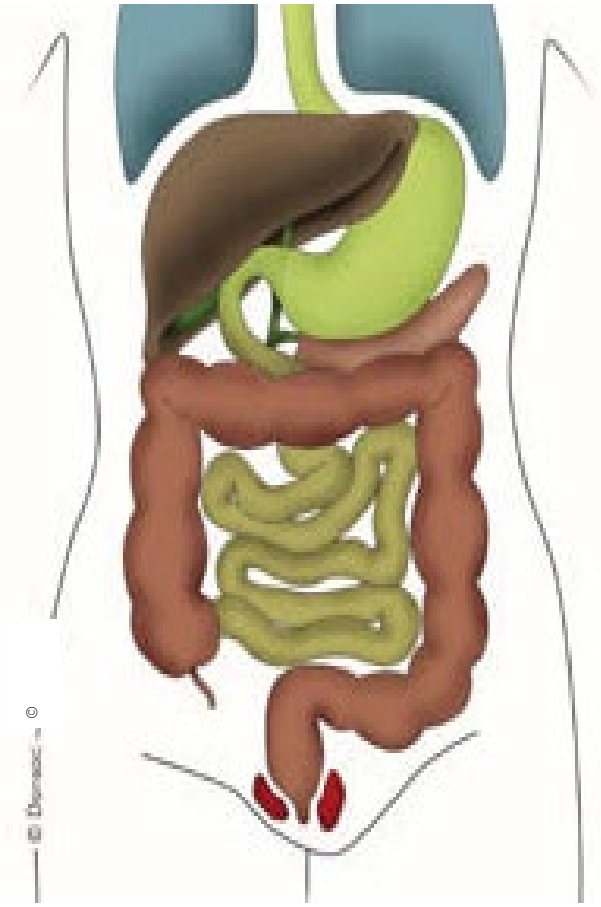
Loop Colostomy

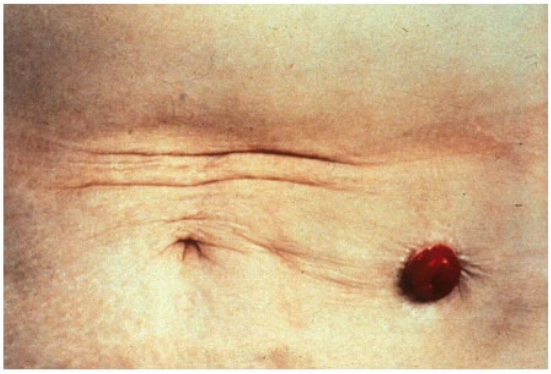




The loop colostomy is brought to the surface of the abdomen in the left iliac fossa, without formerly opening the abdomen. Where the stoma site has been positioned, the surgeon will use a keyhole approach and pull up a piece of large bowel to the surface. The bowel would then be split into the proximal & distal lumen and in the early post-op days a plastic rod is used to keep the bowel to the surface of the abdomen. The Stoma Care Nurse (SCN) will remove the rod at around 4-6 days post-op. The stool will be formed and a closed bag is used.

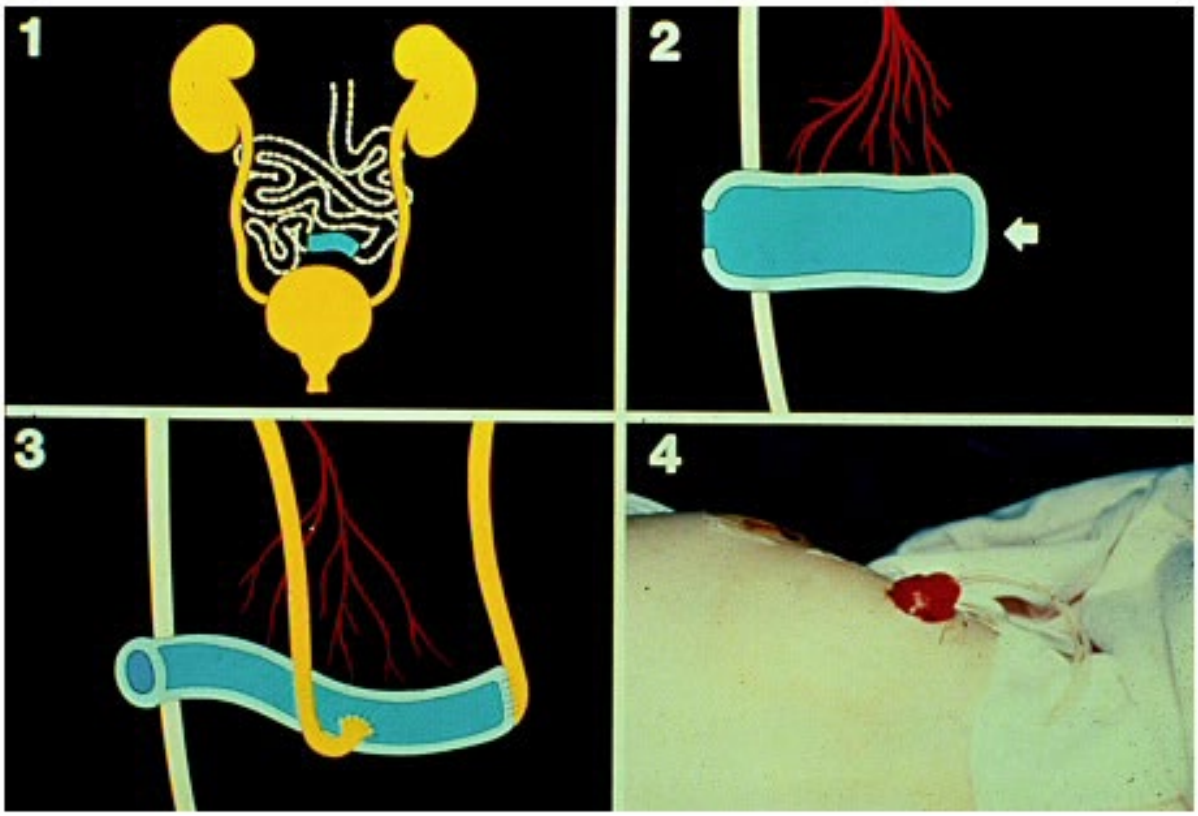
End Colostomy





The end colostomy is situated in the left iliac fossa. Depending on which surgery has been carried out, it will be either temporary or permanent. The stool will be mainly formed and the patient will use a closed bag.

Cystectomy Ileal-Conduit / Urostomy



The urostomy, or ileo-conduit, is the bladder stoma - situated in the right iliac fossa. The surgeon diverts the terminal ileum and uses it as a host to implant the ureters. In the early post-operative days, two uteric stents are placed into the ureters to maintain patency. Over a period of two weeks, the ureters begin to lengthen and eventually fall into the bag.

Due to the terminal ileum being used, it will create a clear mucous, which is naturally secreted by the bowel and can be confused with infection. If there is a concern that there is an infection, either use an intermittent catheter into the conduit to obtain a sample. If this fails, ask the patient to put on a new bag and collect the first bit of urine.

This stoma has a bag with a tap at the bottom for the patient to drain as and when necessary. A night drainage bag can be used to collect the urine overnight.

Types of Stomas and Expected Output

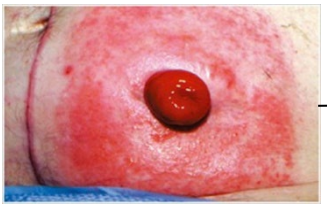
Stoma	Site	Output	Bag Required	Frequency of Change
Loop ileostomy **End ileostomy**	Right iliac fossa	Liquid in the early days Eventually a porridge consistency	**Drainable bag** High output management system required if output is over 1 litre/24 hours. Once output thickens, empty between 3 to 5 times per day.	Can stay on for 3 days Many patients like to change the bag daily Maximum monthly quantity to be prescribed: 30 bags (one piece system), 15 flanges & 30 bags (two-piece system)
Transverse loop colostomy	Upper right quadrant	Semi-liquid in early days Eventually becomes thicker	**Closed Bag** 1-3 bags per day	Maximum monthly quantity to be prescribed: 90 bags closed bags 2-piece system 15 flanges and up to 90 bags per month
Sigmoid colostomy	Left iliac fossa	Semi-liquid in the early days, becomes a formed stool May work 1-2 times per day	**Closed Bag** 1-3 bags per day	Maximum monthly quantity to be prescribed: 90 bags closed bags 2-piece system 15 flanges and up to 90 bags per month
Ileo-conduit/ urostomy	Right iliac fossa	Urine with mucus present	**Urostomy bag** with tap Requires night drainage system at night or bed rest	Can stay on for 3 days Maximum monthly quantity to be prescribed: 30 bags (one piece system), 15 flanges & 20 bags (two-piece system) <u>Night drainage bags</u> Maximum monthly quantity to be prescribed: 4 bags (use a new bag every 7 days, cleaning in between use)

Increase in prescribing of stoma products and accessories

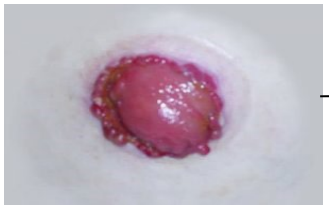
- Poorly fitting appliance will lead to peri-stomal skin problems
- Parastomal hernia can cause problems with the bag adherence
- Weight loss or weight gain can change the stoma template
- Granulomas can bleed and cause problems with bag adherence
- Annual reviews with a Stoma Care Nurse are advised

Stoma Complications

This is sore peri-stomal skin. The Ileostomy is too flush to the skin and the output from the stoma is corrosive, burning the skin. Once an appropriate bag is found to stop the leakage, the skin will heal.



This is a peri-stomal skin reaction to the hydrocolloid of the bag. Once the bag is changed to a new hydrocolloid, the reaction will improve. Sometimes a topical steroid may need to be used to treat the skin.



These are granulomas, almost like warts, that come up around the stoma - they can bleed. The treatment is silver nitrate and the SCN can manage these.

This is a parastomal hernia that can push the stoma out. The patient must be referred to the Stoma CNS to assess whether the bag moulds well around the stoma and a level 3 support belt has been fitted.

Stoma Appliance and Accessory Use

The table below outlines the formulary and/or guideline decisions for stoma appliance and accessory use, according to the Hertfordshire and West Essex Integrated Care Board (HWE ICB) ratified position statements.

Full details for each stoma appliance/accessory can be accessed using either of the following links:

https://www.hweclinicalguidance.nhs.uk/all-clinical-areas-documents/stoma

https://www.westhertsformulary.nhs.uk/chaptersSub.asp?FormularySectionID=33

Stoma patients should use a plain and simple procedure when changing bag, thus avoiding the need for expensive accessories.

Stoma Appliance/Accessory	Decision
Adhesive remover sprays & wipes	Formulary Choice (FC) & Quantity
Adhesive sprays & lotions	STOP
Barrier creams	FC & Quantity
Barrier rings, seals & washers	Quantity
Deodorants, skin cleansers, filters, bridges & bag covers	STOP
Discharge solidifying agents	FC & Quantity
Elastic belts	Quantity
Flange extenders / retentions strips	Quantity
Gauze swabs	STOP
iLEX® skin protection paste & Orabase® paste	Quantity
Paste & fillers	Quantity
Pouch quantities	Quantity
Product samples	STOP
Protective sprays, foam applicators & wipes	FC & Quantity
Stoma collars	Quantity
Stoma powder	Quantity
Stoma support garments - levels 1 and 2	STOP
Stoma underwear - level 3	Quantity

Common Questions Patients May Ask

Will I smell?	• The patient will only notice a smell if they have leaked or when emptying / changing appliance. • The bags are odour proof and have a charcoal filter.
Will I leak?	• Leakage must not be tolerated – refer to SCN • There is always a reason. • Has the stoma shrunk and is the template too big? • Is there a noticeable dip at the side of the stoma that needs an accessory to prevent leakage? • Is the bag too full, causing the adhesive to be compromised?
How will I cope?	• The patient needs a sensitive approach. • Most patients do not accept their stoma for months/years - they only adapt to their new way of life in the early weeks / months. • By approaching these patients with confidence and care you will create a positive environment for your patient.
Can I bathe / shower?	• Yes. The bags are completely waterproof. • Warn the patient that when the adhesive of the bag warms up with the water, it will stick more and so it is best to leave the bag to dry before changing it. • If the patient has a colostomy or urostomy, encourage them to take off the bag and have a shower or bath. Water cannot enter the stoma!
Why is the stoma so big?	• This is due to post-operative swelling. • The stoma will shrink over a 6-8 week period and must be constantly measured to ensure a good bag fit.
Will my stoma get infected?	• Stomas do not get infected. • The patient may get sore skin, but this is only due to poor stoma management or leakage. • it is rare for patients to be allergic to the hydrocolloid used for stoma bags.
What can I eat?	• **Colostomy patients:** Can eat & drink everything, but they may find some foods cause wind. Refer them to the Stoma Team for dietary advice. • **Ileostomy patients**: Need to be warned about foods that are high in fibre and roughage as they can block the stoma - refer to Stoma Team for dietary advice. • **Urostomy patients:** Can eat & drink everything without problems.
Can I cause the stoma harm?	• The stoma may bleed slightly when it is being cleaned. • This is to be expected and the patient needs to be warned of this. • The patient will not have any physical feelings when touching the stoma, as there are no sensory nerve endings in the bowel. • The patient will only be able to feel the skin around the stoma.

Glossary of Terms

ANASTOMOSIS	A surgical joining of the bowel created by the surgeon (e.g. two ends of the bowel being joined).
COLOSTOMY	A surgical operation in which a part of the colon is brought through the abdominal wall to create an artificial opening (stoma).
ILEO-ANAL POUCH	A reservoir made from loops of ileum to replace a surgically removed rectum, avoiding the need for a permanent ileostomy.
ILEO-CONDUIT (UROSTOMY)	A segment of small intestine (ileum) is used to convey urine from the ureters to the exterior (stoma) into an appliance.
ILEOSTOMY	The ileum is brought through the abdominal wall to create an artificial opening (stoma).
LAPAROTOMY	A surgical incision into the abdominal cavity. The operation is performed to examine the abdominal organs as a help to diagnosis.
STOMA	A Greek word for an 'opening'. The artificial opening of a tube (e.g. the colon or ileum) that has been brought through the abdominal wall.
TENESMUS	A sensation or the desire to defecate, which is continuous or recurs frequently, without production of significant amounts of faeces.