Peristomal Skin Issues and Fistula Management

Boone Hospital Wound Healing Center's
4th Annual Conference
September 18, 2015

It is all Perspective!

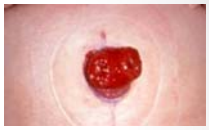
- https://www.youtube.com/watch?v=2T5_0AGdFic

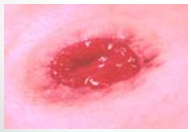
Goals:

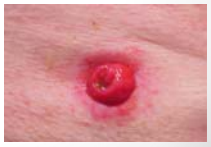
- Ostomy Basics – Patients/Nurses all on the same page
- Preventing and Managing nightmares on the peristomal skin
- Fistulas: Freddie Kruger to nurses

What is an Ostomy?

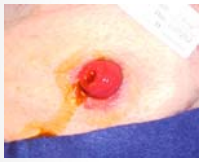
- Ostomy = stoma
- A surgically created opening
- No sphincter
- Characteristics
  - Red, moist, painless
  - Size and shape may change
  - Peristomal skin should be intact







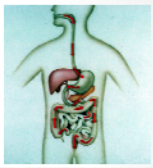
The "Dream" Stoma

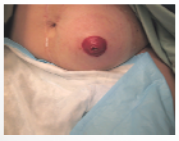


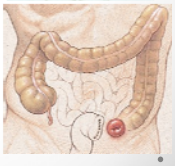
- Proper location
  - Smooth surface
  - Through rectus muscle
  - Where patient can see it
- Color
  - Red color indicates healthy blood supply
- Height (protrusion)
  - Approximately 1" is preferred
- Shape
  - Round
- Location of opening
  - Opening in center of stoma

GI Stomas: Colostomy

- Description: Opening into the colon
- Most common type
- Output
  - Varies: liquid → formed
  - Gas common
  - Odor

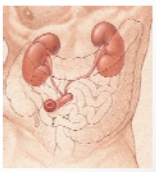






Urostomy or Urinary Diversion

- Description: Opening into urinary system
  - Most common – Ileal conduit
- Output
  - Urine
  - May contain mucus



Two-Piece Pouching Systems

Must have both pieces

Flange type and size must match!

Flange size NOT EQUAL to stoma size

One-Piece Pouching Systems

Skin barrier and pouch are attached

May be easier to use

Most flexible pouching option

Factors That Impact Skin Barrier Wear Time

- Type of discharge
- Skin condition
- Moisture – humidity, perspiration, water
- Frequency of emptying
- Pouching system
  - Right size?
  - Right type?
  - Right application?

Healthy Stoma and Peristomal Skin

- The peristomal skin should be intact without irritation, rash or redness
- A properly fitting skin barrier protects the skin from being irritated or damaged

Basics of Ostomy Care

- Empty the pouch when 1/3-1/2 full
- No products on the peristomal skin (no baby wipes, skin prep, adhesive remover)
- Gently cleanse peristomal skin with paper towel and water, pat dry
- Change the barrier/pouch at the first sign of leaking (burning, itching) – **do not patch with tape**!
- When changing barrier look at back for signs of problems in seal
- Address peristomal skin problems early
- Address leaks or blowout for root

Skin Care Tips

✓Remember, less is better when caring for the skin around your stoma

✓Water & paper towels are sufficient for cleaning the skin around the stoma

✓Remind patient to wash hands after changing or emptying your pouch

✓Soap may leave a residue or film on skin and interfere with adhesion

Skin Care Tips (2)

- ✓Skin prepping wipes decrease wear time
- ✓Things **NOT** recommended for routine skin care around your stoma: soap, creams, lotions, powders, baby wipes, isopropyl alcohol, steroidal medications or ointments
- ✓No skin irritation is "normal." If there is red, broken or irritated skin identify the cause and resolve

Day to Day Tips

- ➢You can shower, bathe or swim with the barrier/pouch
- ➢Some find it convenient with a 2 piece pouch to switch to a different pouch for the shower so that the pouch you wear stays dry
- ➢When emptying pouch it is not necessary to rinse it out, but shorten wear time
- ➢A lubricating deodorant makes emptying easier
- ➢Do not put oils or cooking sprays in your ostomy pouch

Two-Piece Pouching System

1. Measure the stoma using a sizing guide or use a pattern

2. Trace the pattern onto the skin barrier. The skin barrier should fit closely around the stoma.

3. Using scissors, carefully cut an opening in the skin barrier to match the pattern. Do not cut beyond the line on the release liner.

Two-Piece Pouching System

4. Carefully lift an edge of the adhesive and peel downward, gently pushing the skin away from the skin barrier. Properly dispose of used pouch and skin barrier. Do not flush down toilet.

5. Remove the release liner from the skin barrier. Set aside with adhesive facing up.

6. Center the skin barrier opening over the stoma in a diamond shape. For tape bordered barriers, remove the backing paper on both sides and press adhesive against the skin.

Pouching Tips

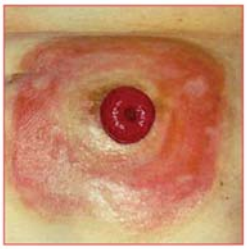
- Prepare new pouching system before you remove used pouch
- Empty pouch when 1/3 to 1/2 full of discharge or gas - Do not let the pouch overfill
- Empty pouch before activities and before bedtime
- If you notice a lot of gas in pouch (colostomy or ileostomy) consider a pouch with a filter

Pouching Tips (2)

- The best time for a routine pouching system change is in the morning before anything to eat or drink
- After application of skin barrier, gently hold hand over the barrier for about 10 minutes for it to melt to skin
- Place two-piece pouching system in a diamond shape for a smoother fit

Skin Irritation

- Peristomal skin irritation will make keeping a seal difficult
- The most important part of dealing with skin problems is to learn what caused the irritation and address it

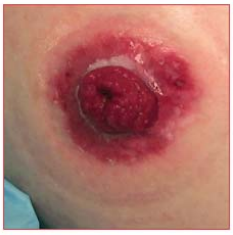


Improperly Fitting Skin Barrier

If the opening of the barrier is too large or the is a leak, the drainage from the stoma will damage the peristomal skin

Suggestions:

- Identify the cause of the breakdown
- Measure stoma size
- Select a product that fits closely around the stoma
- Apply powder to any open skin before applying barrier (crusting)
- Discontinue use of Premium Powder after the skin has healed.

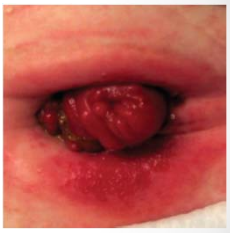


Skin Irritation Due to Leakage

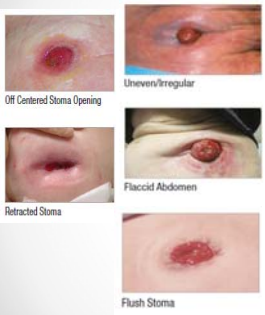
- Stoma output is irritating to the skin, causing redness that can progress to open raw skin that weeps or even bleeds. This type of irritation is often very painful. Ileostomies are at the highest risk because of the type and volume of output. A change in the stoma or the shape of the abdomen lead to leakage.

Suggestions:

- Change your pouch promptly if drainage is leaking under the skin barrier indicated by itching or burning
- Change pouch on a regular schedule before it leaks
- Consider use of accessories (convex skin barrier, belt, barrier rings) to help prevent leakage under the skin barrier



Convexity May be Considered When:



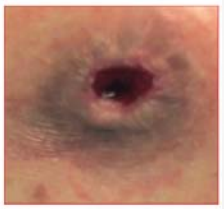
- Convexity is the outward curving of the skin barrier, designed to interface with the immediate peristomal skin
- Convex skin barriers promote a good fit between the barrier & skin where flat barriers would be unsuccessful
- The convexity barrier pushes on the surrounding skin, opens or flattens skin folds or helps the stoma protrude more

Retracted Stoma

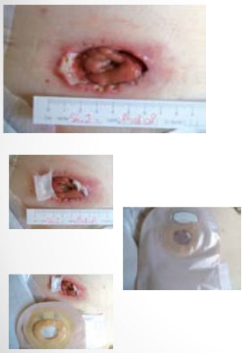
A retraction occurs when the stoma is pulled inward and may be due to poor healing, a thick abdominal wall or excessive scar tissue. A retracted stoma can make it harder to prevent leakage.

Suggestions:

- A convex skin barrier which adds support next to the edge of your stoma.
- An ostomy belt which secures the pouching system to your body



Mucocutanenous Separation

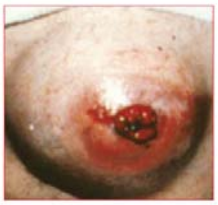


The purpose of the treatment was to prevent the peri-stoma wound and the mucocutaneous separation to be in contact with the stool that delayed the healing of the skin

- 1 piece system.
- After cleaning and drying the stoma, alginate was placed in wound bed
- Ring placed on back of barrier and placed over alginate
- Change q3days

Peristomal Hernia

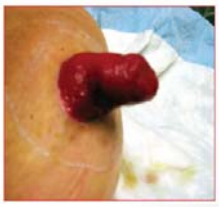
- A peristomal hernia is one of the most common complications of ostomy surgery
- Usually occurs gradually and may increase in size over time
- Impacts securing a seal
- Most commonly managed by use of a support binder.



Prolapsed Stoma

Suggestions:

- Select a pouching system that has more flexibility to accommodate a change in stoma size (e.g., flat, one-piece)
- Cut skin barrier large enough to accommodate the stoma at its largest size
- Support binder to help prevent the stoma from prolapsing
- Apply the pouch while lying down to make it easier to attach
- Immediately contact physician if stoma turns dark in color

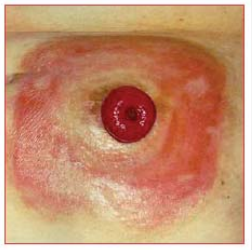


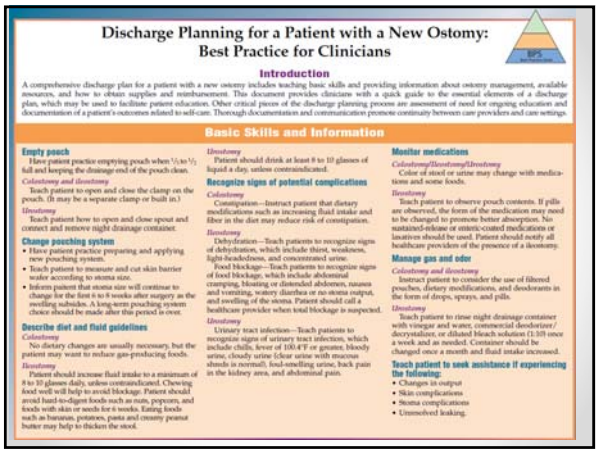
Skin Irritation under Tape

Irritated skin that develops only under the tape of the barrier for a variety of reasons, including sensitivity to adhesives or by stripping

Suggestions:

- Try a pouching system without adhesive tape border
- Limit products on skin such as prep or adhesive removers
- Apply powder to any open skin before applying your new pouching system.





Discharge Planning for a Patient with a New Ostomy: Best Practice for Clinicians

Introduction

A comprehensive discharge plan for a patient with a new ostomy includes teaching basic skills and providing information about ostomy management, available resources, and how to obtain supplies and reimbursement. This document provides clinicians with a quick guide to the essential elements of a discharge plan, which may be used to facilitate patient education. Other critical pieces of the discharge planning process are assessment of need for ongoing education and documentation of a patient's outcomes related to self-care. Thorough documentation and communication promote continuity between care providers and care settings.

Basic Skills and Information

Empty pouch
Have patient practice emptying pouch when ¼ to ½ full and keeping the drainage end of the pouch clean.
Colostomy and ileostomy
Teach patient to open and close the clamp on the pouch. (It may be a separate clamp or built in.)
Urostomy
Teach patient how to open and close spout and connect and remove night drainage container.

Change pouching system
- Have patient practice preparing and applying new pouching system.
- Teach patient to measure and cut skin barrier wafer according to stoma size.
- Inform patient that stoma size will continue to change for the first 6 to 8 weeks after surgery as the swelling subsides. A long-term pouching system choice should be made after this period is over.

Describe diet and fluid guidelines
Colostomy
No dietary changes are usually necessary, but the patient may want to reduce gas-producing foods.
Ileostomy
Patient should increase fluid intake to a minimum of 8 to 10 glasses daily, unless contraindicated. Chewing food well will help to avoid blockage. Patient should avoid hard-to-digest foods such as nuts, popcorn, and foods with skin or seeds for 6 weeks. Eating foods such as bananas, potatoes, pasta and creamy peanut butter may help to thicken the stool.
Urostomy
Patient should drink at least 8 to 10 glasses of liquid a day, unless contraindicated.

Recognize signs of potential complications
Colostomy
Constipation—Instruct patient that dietary modifications such as increasing fluid intake and fiber in the diet may reduce risk of constipation.
Ileostomy
Dehydration—Teach patients to recognize signs of dehydration, which include thirst, weakness, light-headedness, and concentrated urine.
Food blockage—Teach patients to recognize signs of food blockage, which include abdominal cramping, bloating or distended abdomen, nausea and vomiting, watery diarrhea or no stoma output, and swelling of the stoma. Patient should call a healthcare provider when total blockage is suspected.
Urostomy
Urinary tract infection—Teach patients to recognize signs of urinary tract infection, which include chills, fever of 100.4°F or greater, bloody urine, cloudy urine (clear urine with mucous shreds is normal), foul-smelling urine, back pain in the kidney area, and abdominal pain.

Monitor medications
Colostomy/Ileostomy/Urostomy
Color of stool or urine may change with medications and some foods.
Ileostomy
Teach patient to observe pouch contents. If pills are observed, the form of the medication may need to be changed to promote better absorption. No sustained-release or enteric-coated medications or laxatives should be used. Patient should notify all healthcare providers of the presence of a ileostomy.

Manage gas and odor
Colostomy and ileostomy
Instruct patient to consider the use of filtered pouches, dietary modifications, and deodorants in the form of drops, sprays, and pills.
Urostomy
Teach patient to rinse night drainage container with vinegar and water, commercial deodorizer/decrystallizer, or diluted bleach solution (1:10) once a week and as needed. Container should be changed once a month and fluid intake increased.

Teach patient to seek assistance if experiencing the following:
- Changes in output
- Skin complications
- Stoma complications
- Unresolved leaking.

You are the Resource…don't be the Only One!

- **UOAA**
- **Manufacturer's CWOCN**
- **Manufacture Samples**
- **Cancer websites**
- **National Distributors**

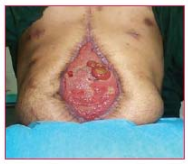
Be Current!

- Would you go to Best Buy for help and be happy with an associate who only knew a 2003 Mac?
- Know Best Practice - Not old practice
- Share evidence based suggestions
- Know what concerns your patient – get the knowledge to know how to manage it or the resources for the patient to go to
- Talk to your patients 6 months later – they will be the experts!

Fistula 101

An abnormal opening between two hollow organs or between a hollow organ and the skin

Predisposing factors for fistula formation include impaired ability to heal after surgery, Crohn's disease, breakdown of intestinal anastomosis, or infection



Fistula in an open abdominal wound

Examples of Fistulas

- **Enterocutaneous fistula** – An opening between the small intestine and the skin. Drainage will likely be liquid, may be high volume, and will contain digestive enzymes that are damaging to the skin.
- **Colocutaneous fistula** – An opening between the colon and the skin. Output can be liquid to semi-formed in consistency, are usually malodorous and may contain gas.
- **Vesicocutaneous fistula** – An opening between the bladder and the skin which drains urine.
- **Spit fistula or esophagostomy** – An opening between the esophagus and the skin that drains mucus and any fluids that may be given orally.

Enterocutaneous fistula

Challenges Associated with Fistula Management

- Although there are predisposing factors, often a fistula is an unplanned occurrence related to surgery or disease and, therefore, challenging for patients, families, and caregivers
- Usually located in difficult areas for management, i.e., near or in incision lines, creases, tubes or other fistulas
- Often the fistula opening is at or below skin level and drainage is often corrosive to skin, malodorous, and may be of high volume

Key Goals for Nursing Management

Protect the skin – The output from a fistula can be very irritating to the skin and contributes to pain. A skin barrier can protect the skin from contact with the drainage

Contain the output

- If the output is minimal absorbent dressings may be sufficient
- If the volume of the output from the fistula is grater a pouch may be needed to protect the skin from exposure to the caustic output

Measure the output – A high output fistula will result in a loss of fluids and electrolytes and require a pouching system

- A bedside collector can allow accurate measuring of I&O's
- A bedside collector will provide longer wear time to the barrier

Key Goals for Nursing Management

Manage costs – Care of fistulas can be costly in terms of supplies and human resources.

- Using a pouching system and appropriate accessories can be more cost-effective and manageable than frequent dressing changes

Control odor – Containment of the drainage in a pouching system, even in small quantities, can manage odor effectively

- Other accessory products also can assist with odor control when the pouch is changed or emptied

Provide patient comfort – Effectively managing a fistula can contribute to patient dignity

- Protecting the skin, collecting the discharge, containing costs, and controlling odor all contribute to patient comfort

Equip Yourself and Empower your Patients

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