# OSTOMIES

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# Ostomies

- **Ostomy**
  - Opening into the abdominal wall that serves as an exit site from the bowel or ureter.
- **Stoma**
  - Portion of bowel or ureter that is surgically opened and brought to abdominal wall.

# Ostomies

- **Ureterostomy**
  - Surgical procedure creating an opening from the ureter to the abdominal cavity.
- **Colostomy**
  - Surgical procedure creating an opening from the large intestines to the abdominal wall allowing passage of feces.
- **Ileostomy**
  - Surgical procedure creating an opening from the small intestines to the abdominal wall allowing passage of feces.

# Ostomies

- **Effulent**
  - Drainage from a stoma.

- Type of drainage depends on location of ostomy
  - Ileostomy and ascending colostomy – liquid feces.
  - Transverse colostomy – mushy stool.
  - Descending – more soft to solid.
  - Ureterosotomy – drains urine.

# Ostomies

- Temporary or permanent.
- Depend on underlying disease and diagnosis.
- Temporary can be several weeks to several months.

# Ostomies

- **Temporary colostomies** – generally located at transverse colon.

- **Permanent** – usually located at descending colon or sigmoid colon.
  - Permanent because the colon or rectum have been removed.

# Ostomy Appliances

- Many types of appliances/pouches available.
- **One piece**
  - One unit bag attached to wire.
- **Two piece**
  - Wafer is separated from pouch.
- **Wafers**
  - Some precut  and some must be custom fit.
- **Sealant or paste**
  - Create a seal.
- **Closure**
  - Clip or clamp.

# Ostomy Care

- Wash hands
- Don gloves
- Remove old appliance
- Take note of effulent
  - Color, consistency, amount, and odor.
- Drain effluent into commode.
- Discard old appliance into biohazard bag.

# Ostomy Care

- Assessing initial post-operative stoma
  - Initially post-operatively stoma is edematous and has slight bleeding.
  - Monitor for post-op complications
    - Excessive bleeding.
    - Stoma dark in color or blanched due to lack of blood supply.
    - Drying of stoma.
    - Signs of infection.
  - It can take 4-6 weeks to determine stoma size.

# Ostomy Care

- Stoma should be pink to red and moist.
- Assess for ulcerations, cuts, necrosis, and any other abnormal findings.
- Assess skin around stoma.
- Note any redness or irritation.
- Report any abnormal findings immediately.

# Ostomy Care

- Nursing Implications
  - Skin breakdown – major problem.
  - Enzymes in stool cause excoriation.
    - Wash stoma with soap and water and pat dry to prevent skin integrity.
    - Skin barrier substance – prevents breakdown around stoma.
    - Enterostomal therapy – specializes in care of ostomies.

# Applying Appliance

- Application depend on type used.
- Pre –cut
  - appropriate size is chosen and then applied.
- Custom
  - use an ostomy guide to cut the opening on the wafer 1/16 to 1/8 larger than stoma.
  - Key is to fit around the stoma without touching stoma or exposing surrounding the skin.

# Applying Appliance

- One piece system – use skin sealant.
- Two piece system – use paste.
- Appliance chosen depends on type of ostomy, stoma shape, location of stoma, trail and error.
- May reinforce appliance with non- allergic paper tape in picture frame method.
- May wear an ostomy belt.
- Roll end of pouch upward once and apply clip/clamp.
- **Be sure it is snug.**

# Ostomy Assessment

- As with an GI assessment you monitor
  - Bowel sounds in all 4 quadrants.
  - Effulent from ostomy – empty when 1/3 – ½ full.
  - Abdominal assessment.
  - Stoma appearance.

- Report immediately any abnormal findings with stoma, absence of bowel sounds, and activity from ostomy by 3rd day.

# Ostomy Care

- Management Of Ostomies
  - Review skill 31 -4 pgs 754 -756
    - Observe stoma pink and moist.
    - Skin clean, dry and intact.
    - No signs of redness, irritation, or excoriation.
    - New appliances adheres to skin without wrinkles or gaps.

# Colostomy Irrigation

- Requires Dr. order
- Procedures
  - Remove appliance.
  - Place irrigation sleeve over stoma.
  - Instill lubricated cone into stoma.
  - Insert catheter into cone.
  - Instill 500cc to 1000cc tap water or saline.
  - Start with 500 cc over 5-10 minutes.

# Urinary Diversion

- Surgical opening on the abdomen or ostomy through which urine is eliminated.
  - Types continent and Incontinent
    - Continent diversion
      - Internal pouch or reservior created from a segment of small bowel.
      - Patient performs self – catherization q 4-6 hours.
      - No appliance used.

# Urinary Diversion

- Incontintent urinary diversion
  - AKA – Ileal conduit
- Ureter
  - Transplanted into a closed off portion of ileum with an opening to outer abdomen creating a stoma.
- Ureterostomy
  - One or two ureters are brought to abdominal wall and stoma is formed.
  - Requires a pouch or appliance because of continuous urinary drainage.
  - Assess stoma and apply appliance as with ostomy.
  - Appliance vary in that have drain spout.

# Urinary Diversion

- Urinary Diversion
  - Nursing Implications
    - Due to urine draining continuously, there is an increase chance of skin breakdown.
    - Need to change appliance more frequently due to weight of urine in bag.
    - Place a tampon in stoma to absorb urine while skin is being cleansed.
    - Peristomal skin – skin around stoma that is hard to keep from breaking down – frequent changes and ammonia in urine.
    - Skin barrier products, antibiotic or steriod ointment is applied.