



The Outlet

New Zealand Stomal Therapy Nurses

In this issue:

- 2018 NZNOCSTN Conference
- Vann's Ostomy Challenges
- Accepting that not all things are fair or fixable
- Phosphate enema through colostomy
- Troublesome Stomas

JULY 2018

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in mind



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The Outlet

New Zealand Stomal Therapy Nurses

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ENCOURAGING MEMBERSHIP

EASY MEMBERSHIP SUBSCRIPTION CAN NOW BE GAINED ON THE WEB SITE
www.nzno.org.nz

IF YOUR ADDRESS HAS CHANGED PLEASE CONTACT

Jackie Hutchings

Email: jacquelyn@nursemaude.org.nz

Your Executive Committee Members

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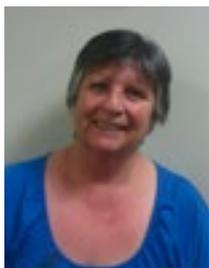
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Chairperson's Report

BRONNEY LAURIE



We are now officially half way through the year and the shortest day is over. The committee is working very hard regarding the conference in Auckland in October and I sincerely hope that you can all attend.

We are still looking for nurse presentations and don't forget the Liberty Award. Abstracts were due for this in June, but we are happy to extend this.

It is an exciting programme with some wonderful speakers and I am looking forward to the night out. We have managed to keep the price the same as the last conference and there are many places around central Auckland to stay. It is so important for us all to attend as it ensures we are keeping our practice current, updates our PDRP's and it is a time for us all to meet and support one another. I look forward to seeing you all in Auckland.

I was very lucky to attend the World Conference of Enterostomal Therapists in Kuala Lumpur, Malaysia in April. It was an awesome experience. I learnt a great deal and it was interesting to compare our practice to others overseas. It was a chance also to network with others from around the world as 54 countries attended. I would like to mention Fran Martin from Auckland who has represented us all within the WCET forum. We sincerely appreciate it; thank you Fran for taking the time to ensure we have a voice.

We are extremely privileged to have the support of all our Trade companies to be able to attend conferences and education seminars. We are all very aware that it has become more difficult to receive funding or be allowed the time off in various District Health Boards. This is disappointing but true, so to all the companies I say a big thank you.

Whilst I was in Kuala Lumpur I had the opportunity to speak with the Chairperson of the WCET, she was very disappointed to hear that New Zealand still does not have an education programme for Stomal Therapists. She was very keen to give us support. The committee have also had support from the South Island Directors of Nursing and ARA Polytech in Christchurch has been approached about providing a level 7 paper. I do understand that funding for level 7 is almost impossible for some but my understanding is that this is changing and may benefit those who wish to complete this qualification.

The committee has been in touch with ARA and I personally am excited that we may indeed be able to offer something that will see nurses qualified and supported in their roles as STN's. This is important to accomplish for all Stomal Therapists of the future and I am very determined to ensure that it does happen.

I look forward to seeing you all in Auckland at conference, make the most of the early bird offer. Please consider becoming part of the committee in October.

Kind regards,

Bronney





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small product to make
such a *big difference*”**

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Editor's Report

JACKIE HUTCHINGS



As I write this it is 7 degrees outside and although it is not raining it is a horrible grey day but on the bright side I can also see the camellias outside my window already bursting into flower, so winter can't go on forever!

Our conference in Auckland is approaching swiftly and at that conference I will be stepping down as I will have completed two terms, and in fact have been on the committee four times previously, so in my 35 years of stomal therapy more than half has been spent on the Section and then College National Committees.

I urge you to consider standing for the committee, it has been very rewarding for me as I learn more about how stomal therapy works around New Zealand and also having more time with the fantastic nurses who work in this profession. I have always really appreciated the time I have spent with all the people I have worked with on these committees over the years.

As I write this I have just been through (and am continuing on) with a very stressful six weeks. We had to bring my mother in law up from Invercargill quite hurriedly as she was suffering badly from depression due to grief and loneliness and did have suicidal ideation as well. After a very stressful week with us where we had to find a roster of people who could take time off work to stay with her, we had her admitted to a psychogeriatric ward where she was started on anti-depressants and sleeping tablets.

You may wonder why I am telling you all this and there are two reasons. One is that it can be emotionally soothing just to get things known as I continue to work full time in an extremely stressful work environment and spend all my spare time sorting things out for her as in that six weeks we have also found a serviced apartment for her and sold her villa in Invercargill.

I flew down one day and sorted out what was to come up and then drove her car home. Her furniture is up, and she has moved into her new apartment but still suffering some "blips" in her mental wellbeing that have necessitated two GP visits this week. I am hoping things will improve soon!

Secondly, and most importantly, it has made me think a lot about our patients and their families and how they cope with carer stress and fatigue. There is not enough emotional support out there. We have no access to a clinical psychologist in the surgical services at Christchurch Hospital – something that is sadly lacking. GPs can arrange counselling sessions but in many instances this requires payment in already financially stretched families.

The patient may be depressed due to a change in body image or a diagnosis they are finding hard to accept or their families may be experiencing similar difficulties with not knowing what is best to help them. Some patients can become quite verbally and even sometimes physically aggressive with their families thinking that they do not understand. We can not be there all the time to help and these behaviours can go on for a long time.

You will read Jennifer Rowland's article further on in this Journal, I found it interesting that she should send in that article just after I had written my editor's report. The Journal is a great place to express your views, what help is available in different areas around NZ? Do you have access to emotional support for your patients and what do you see as your role?

Please remember that the Journal is yours. Articles are always appreciated and can be very thought provoking whether it be a case study, an unusual condition or something to do with your practice. Many of you work in isolation so send in your articles so that we can all learn from each other.

I look forward to handing over the Editor's role in Auckland following the conference, but I am also happy to help whoever takes on the job. Please consider taking this on as it is very rewarding and would look good in your portfolio!

Jackie Hutchings



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into healthy stoma skin



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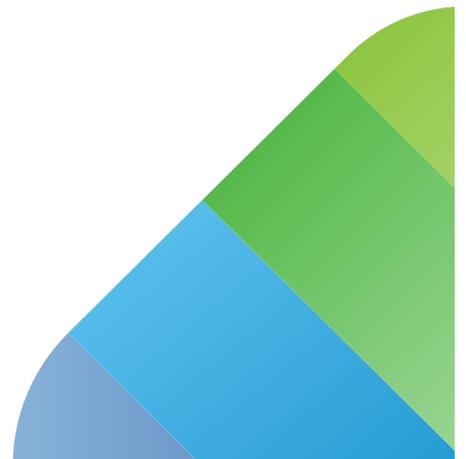
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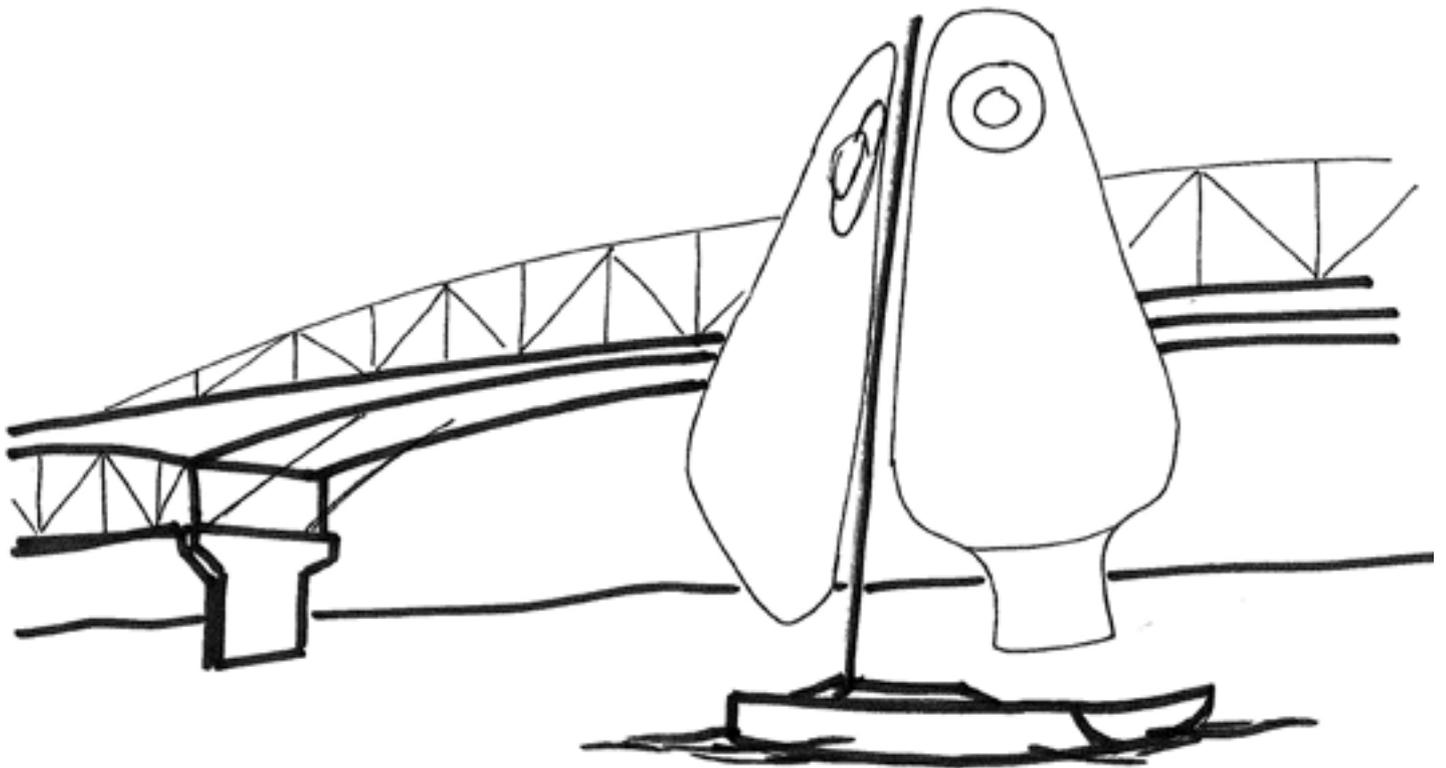


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SET YOUR SAILS



Stomal Therapy Conference

Rydges, 59 Federal Street, Auckland

October 18 – 19, 2018

Set Your Sails - Tentative Programme

Thursday 18 October

- 0730: **Registration**
- 0800: **Mihi Welcome**
- 0825: **Welcome**
Bronney Laurie – Chairperson
- 0830: **Nepal**
Ian Bissett – Colorectal Surgeon
- 0915: **Paediatric Stomas**
Mr Price – Paediatric Surgeon
- 0945: **Intestinal Failure Service**
Briar McLeod
- 1000: **Morning Tea**
- 1020: **Intestinal Failure**
Julian Hayes – Colorectal Surgeon
- 1050: **Short Gut syndrome**
Kerry McIlroy – Dietician
- 1110: **Fistula Management**
Mary Vendetti – Nurse Presenter
- 1130: **NZNOCSTN BGM**
- 1230: **Lunch**
- 1330: **Caring for the Carer**
Nic Marcon – Psychologist
- 1430: **Inflammatory Bowel Disease**
Jacqui Fletcher
- 1500: **Afternoon Tea**
- 1520: **Siting**
Bronney Laurie – Nurse Presenter
- 1540: **TBA**
Nurse Presenter
- 1600: **Federation NZ Ostomy Societies**
- 1620: **Learning Packages**
Bronney Laurie
- 1630: **Close**
- 1900: **Dinner – Ocean Eagle (Nautical Theme)**

Friday 19 October

- 0800: **Registration**
- 0830: **Stoma Creation**
Nagham Al Moznay – Colorectal Surgeon
- 0915: **Mesh Hernia Repairs**
Colorectal Fellow
- 1000: **Morning Tea**
- 1020: **Scoping**
Debbie Perry
- 1040: **Role of Oncology CNS**
Felicity Drumm
- 1105: **Gynae Surgery**
Lois Eva – Gynae Surgeon
- 1155: **History of Stoma Bags**
Fran Martin – Nurse Presenter
- 1215: **Lunch**
- 1315: **Trades**
- 1330: **Patient Perspective**
Joshua Bardell
- 1400: **Q&A Session**
Panel
- 1500: **Close**

Call for Abstracts

If you are interested in presenting at conference please forward an abstract to jacquelynh@nursemaude.org.nz

Please remember that Liberty is offering an Award of \$2000 to the best presenter to be used for education.

Call for Rule Remits and Discussion Items for the BGM

If you have any Rule Remits or items for discussion at the BGM can you please forward them to:
jacquelynh@nursemaude.org.nz

Rule Remits should be clearly written and give a rationale for the change.

Please give consideration to joining the Executive Committee – 3 members have to stand down having completed two terms. There will be 4 vacancies on the committee – training is offered. Being on this committee is a very rewarding experience and is often a lot of fun. Please approach any current committee members for further information. A nomination form can be found in this edition of The Outlet. Any member of the College can hold an office position regardless of whether they are working in the role or not.

The above programme is subject to change.

NZNO College of Stomal Therapy Nursing Conference

SET YOUR SAILS – REGISTRATION FORM

18 -19 October 2018

Rydges, 59 Federal Street, Auckland, New Zealand

Tax invoice GST # 10 386 969

Please print clearly

Name: _____

Address: _____

Telephone Home: _____ Work: _____ Mob: _____

Email: _____

NZNO Member: YES NO

Membership number: _____

Full Fee	\$320	Includes morning and afternoon teas, lunches and social event – Thursday night
Early bird before 01/09/18	\$290	Includes morning and afternoon teas, lunches and social event – Thursday night
One day only	\$160	Includes morning and afternoon tea and lunch
Social Event	\$80	Partners or single day registrants

NB All registration fees are inclusive of GST

Social Event: Ocean Eagle Harbour Cruise – Dinner and Dance – 7pm to 11pm
Theme: Nautical

I will be attending the Thursday Evening Social Event YES NO

Do you have any special dietary requirements?

- GLUTEN FREE VEGETARIAN
 VEGAN OTHER (PLEASE SPECIFY) _____

ACCOMMODATION

Each delegate is responsible for booking their own accommodation. Special conference rate is available at Rydges – please request on booking

REGISTRATION

Please complete and return this form before 1 September 2018 for early bird registration or at the latest 10 October 2018

PAYMENTS

Internet banking/ direct, credit card: using your bank's internet banking website.

Account details: ANZ Bank, NZNO Stomal Therapy Section a/c no: 010505-0097186-00.

Please ensure that your payment quotes the initial of your first name and your full surname.

NB: Scan and send completed registration form to College Secretary: leeann.thom@southernhb.govt.nz

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Nomination Form for NZNO College of Stomal Therapy Nursing Executive Committee

(Please print clearly)

I, _____ wish to nominate _____
(Your name) (Surname) (Given Name)

for the position of Committee Member NZNO College of Stomal Therapy Nursing.

Signed: _____ Date: _____

This section to be completed by Nominee

I _____ accept nomination as Committee Member of the NZNO College of Stomal Therapy Nursing.

Address (Personal):

Address (Business):

Phone: _____

Phone: _____

Email: _____

Email: _____

Area of current work: _____

NZNO Membership No.: _____

Length of time as member of NZNO College of Stomal Therapy Nursing: _____

Work-Experience, including level of responsibility: _____

Explain briefly why you think you are suitable for this position (if relevant include previous committee experience):

Signature: _____ Date: _____

Please return the completed nomination form to Diana Geerling, PO Box 2128, Wellington 6140 or dianag@nzno.org.nz by September 21, 2018. To be valid this form must be signed by both parties and be received by the closing date.

Application for Bernadette Hart Award

CRITERIA FOR APPLICANTS

- Must be a current full or life member of the NZNO College of Stomal Therapy Nursing (NZNOCSTN) for a minimum of one year
- Present appropriate written information to support application
- Demonstrate the relevance of the proposed use of the monetary award in relation to stomal therapy practice
- Provide a receipt for which the funds were used

- Use award within twelve months of receipt
- Be committed to presenting a written report on the study/undertaken or conference attended or write an article for publication in The Outlet or to present at the next national conference

APPLICATIONS CLOSE 30TH NOVEMBER (Annually)

SEND APPLICATION TO:

Jackie Hutchings

Email: jacquelynh@nursemaude.org.nz

BERNADETTE HART AWARD APPLICATION FORM

Name: _____

Address: _____

Telephone Home: _____ Work: _____ Mob: _____

Email: _____

STOMAL THERAPY DETAILS

Practice hours Full Time: _____ Part Time: _____

Type of Membership FULL LIFE

PURPOSE FOR WHICH AWARD IS TO BE USED

(If for Conference or Course, where possible, please attach outlined programme, receipts for expenses if available)

- Outline the relevance of the proposed use of the award to Stomal Therapy

EXPECTED COSTS TO BE INCURRED

Fees: (Course/Conference registration) \$ _____

Transport: \$ _____

Accommodation: \$ _____

Other: \$ _____

Funding granted/Sourced from other Organisations

Organisation:

_____ \$ _____

_____ \$ _____

_____ \$ _____

PREVIOUS COMMITMENT/MEMBERSHIP TO NZNOSTS

Have you been a previous recipient of the Bernadette Hart award within the last 5 years? No Yes (date) _____

Please Indicate ONE of the below: (please note this does not prevent the successful applicant from contributing in both formats).

Yes I will be submitting an article for publication in 'The Outlet' (The New Zealand Stomal Therapy Journal).

Yes I will be presenting at the next National Conference of NZNOCSTN.

Signed: _____ Date: _____

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TRIPARTITE COLORECTAL MEETING 2020



9-12 NOVEMBER, AUCKLAND, NEW ZEALAND

Looking Forward, Looking After | Mā Muri Ki Mua

Save the Date - Tripartite 2020 Meeting

We are excited to announce that the [2020 Tripartite Colorectal Meeting](#) will take place from **9-12 November 2020** at the New Zealand International Convention Centre in beautiful Auckland, New Zealand. **Mark these dates in your calendar now.**

This Meeting is the pre-eminent event for global leaders in Colorectal surgery and will offer outstanding opportunities for professional development and personal connection.

Come to Tripartite 2020 and:

- Be inspired by top international experts;
- Keep up with the latest research and developments in the field;
- Engage with the most pressing issues facing the field today;
- Meet colleagues from around the world – connect, learn and share with others who are passionate about your field;
- Share your research by presenting a paper or poster – make your own contribution to the field and raise your professional profile. We'll be calling for abstracts in late 2019.



Vann's Ostomy Challenges

**Jenny Coulson
and the Cleaver Family**

Taranaki



Vann's story covers the problems of adhesion and volume requirement due to excessive air gulping that transit through to his pouch.

Children don't have a great distance from umbilicus to pubic bone to iliac crest so the flexibility of the pouch was as important as the adhesion.

The photos attached show the system we devised. Initially Abby (Mum) was confused by the idea but it wasn't long before she put the idea into practice with excellent results all round. Vann's ileostomy is very flush to skin level, however using a Salts pouch (NDAL1390) and a Salts Mouldable Seal for 12 hours suited his peristomal skin perfectly.

CLEAVER FAMILY

We are the Cleaver family. Mum, Dad and four children. Our youngest child Vann was born with multiple disabilities due to a chromosome disorder. Vann was diagnosed with Hirschsprungs Disease and has had an ileostomy since 5 days old.



At 2 years old Vann had surgery to have his entire large bowel removed, so Vann will forever have an ostomy.

Due to Vann's chromosome disorder he is very delayed, he has just learnt to walk a few days before his sixth birthday. For six years Vann would crawl and roll his way around to get to everything he wanted. This made it extremely hard for us to get ostomy bags to stick with the way he would move around. Vann would constantly leak, it was a nightmare, we felt we couldn't go anywhere as if we did he was sure to leak. On average when Vann was younger we would go through about 4-6 bags in a day. None of them seemed to take to his skin very well, if he sat in a car seat or push chair the bag would crease which would allow it to seep out.

Vann is unable to eat food so he is on a liquid diet, this meant his output was extremely runny so any sort of lift on the bag or crease it would leak. Vann was constantly on the go flipping his body around, as soon as we put the bag on within half an hour we would find creases. We tried everything! Multiple brands, thickening his formula, trying to bulk him up with benefibre, nothing worked. That was our life, constantly changing poo bags what seemed like all day and poor little Vann always having mess come out on his clothes. We would have to bath Vann 2-3 times a day.

That wasn't our only issue. As Vann would not eat food he would drink his formula via a bottle. However, when Vann drinks from a bottle as he has oral issues he would take in a huge amount of air each swallow which of course needs to come out somewhere. While during the day was fine I could let it out, it was the night time that was a battle.

Vann would go to bed at 6pm with a brand new bag on, I would empty the wind at 11pm before I would go to bed. I would then set an alarm for 2 or 3am to wake up and let more wind out. Then by the time he would wake at 6am he would be covered in poo, top to toe, because there would have been so much wind it would lift the bag off his skin. It would be everywhere, through his pyjamas, and all through his linen and the battle would start again.

I was exhausted, having to go to bed so late, having to wake up through the night and getting up through the night I would then struggle to get back to sleep. Sometimes by the time I would get back to sleep Vann would be waking up to start his day. It was hard work, we managed but it was so hard. I wasn't sure how I was going to do this forever, it didn't seem fair on anyone especially little Vann and I was shattered.

Thanks to our amazing stoma nurse, Jenny, who knew our battle and always persisted in trying to find a better option. She has been there with us since arriving home with Vann's new ostomy as a brand new baby from Waikato and continued to search options to try and make life better.

Then the day came that she introduced us to the Salts bag. Wow this bag has been AMAZING, it has completely changed our lives and I am forever grateful. I put one on Vann in the morning and it lasts all day! It has an incredible stick to Vann's skin, it flexes and moves with his active little body, it even stays on and lasts through the days he has swimming lessons. We can now go out as a family and not worry that it's going to leak. I don't even take all his supplies with me everywhere he goes now. He can attend school and his teacher aides don't have to change him. It truly has been a blessing to our family.

We have even solved our night time battle, I bath Vann before bed and place a new Salts bag on, I cut a slit in the bag and then place a large Dansac bag over it. This essentially gives us more space due to Vann's large liquid output and his huge amount of wind overnight. I put Vann to bed at 6pm and he sleeps straight through 12 hours without me having to empty his wind at all. I can now go to bed earlier and get a decent 7-8 hours of sleep each night. Even after 12 hours when Vann wakes he has not leaked. His two bags are filled with poo and wind but he doesn't leak. The Salts bag has such an incredible stick to his skin. I did try double decking two Salts bags however found for some reason overnight Vann would leak slightly through the Salts filter. I tried a couple of other bags over the top of the Salts bag but sometimes they would leak and the Dansac bag seems to stick really well with the Salts bag.

So in a nutshell. The Salts bag has changed our lives for the better and we as a family are forever grateful.

HOW JENNY DOES IT



1 First I take the Salts and Dansac bags



2 I cut the holes; the Salts bag I cut to Vann's stoma size and the Dansac bag I cut a lot larger so I can see through and that I am placing the bag correctly around his stoma.

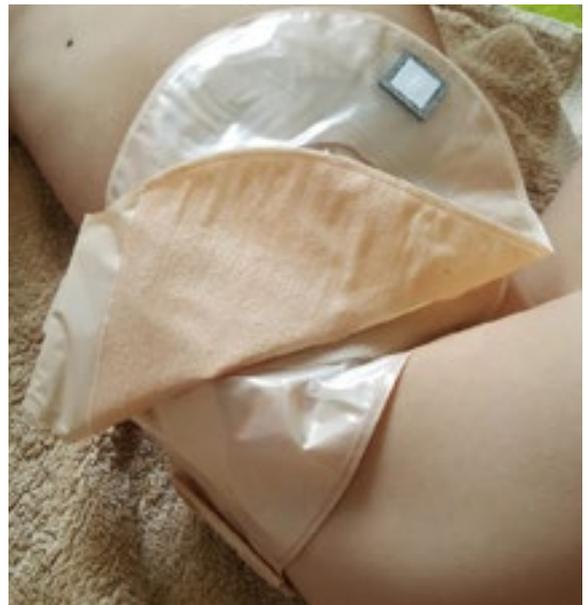


3 Then I cut a good size slit in the Salts bag. This allows the wind and poo to flow through into the Dansac bag overnight

- 4 I then take the Dansac bag, peel the bag off and place it directly over the Salts bag with the slit bang in the middle of the large hole



- 5 Here is the finished product of the double bagging. I take the backing off the Salts bag and place the double bag over Vann's stoma





Healthy skin for a healthy soul.

Brenda, ileostomy since 2011
Terence, colostomy since 2014

Life with a stoma can be complicated. Skin health shouldn't be.

What happens when your patients are not worrying about stoma-related skin problems? Life happens!

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Accepting That Not All Things Are Fair or Fixable

Jennifer Rowlands

Ostomy Clinical Nurse Specialist

Older Adult and Home Health, Waitemata DHB



The role of the Stomal Therapy Nurse (STN) is one that many people have little to no understanding about. I often find myself avoiding the casual and normal conversation of “what do you do as a job?” knowing that it isn’t a straightforward answer.

So to avoid this semi-awkward conversation I often answer by saying I am a community nurse. I mean how many times have you had to explain what a stoma actually is with the identification point of the STN role commonly being when explaining about people that have a bag attached to their stomach. So instantly I see why I am the ‘bag’ lady. Straightforward right, make a few choices about which bag to use, educate the patient and then they’re back living their life independently in society. Wrong. I thought I had a pretty good understanding of the complexity of the STN role before starting nearly two years ago, having worked as a District Nurse for six years and then District Nurse Clinical Nurse Educator for three. I stepped into this speciality role with a holistic care approach like any of my clinical nursing roles to treat the person and not just the disease or diagnosis. But nothing had prepared me for the level of support patients with a stoma (ostomates) require and deserve pertaining to their psychological health and wellbeing.

Nurses who are involved in an ostomate’s care know, from practice, the diversity that exists relating to what the impact of having a stoma has on their quality of life, and this is whether the stoma is permanent or temporary. This can also be said for the adaptation and acceptance of having a stoma. For some ostomates this takes more time than others, with some I think never reaching that level of acceptance of life with a stoma. Negative feelings such as anxiety, depression and anguish arise (2), particularly when returning home and finding their way back into their everyday life, with up to one in four patients (26%) developing a psychological issue. This return to their previous social role and function brings its own challenges. The STN needs both the time and skills to reduce the individual concerns surrounding these, to optimise the recovery and rehabilitation for every new ostomate.

Studies have shown the importance of a pre-operative approach, and the positive contribution this has on an ostomate’s adaptation and coping skills pertaining to life with a stoma (6). Furthermore the need for emotional, social, cultural and spiritual aspects appear

as the main themes, with pre-operative siting for elective surgery providing an avenue for this care either as a pre-operative clinic appointment or as a community visit in a patient’s home. Beyond increasing the possibility of an appropriately formed stoma by the actual physical siting of the stoma pre-operatively, this appointment also starts that journey of adaptation to life with a stoma, with successful rehabilitation for ostomates starting in this pre-operative stage (1). This opportunity not only allows time for patients and their families to ask questions but allows time for that important STN and patient/family relationship to develop, one that I quickly learnt reduces a lot of anxiety for ostomates. With the care of their stoma often appearing to rule their lives and having a direct link to their quality of life, those first few weeks to months are a particularly important part of an ostomates episode of care, as I feel it affects whether they will adapt to life positively with a stoma or not.

This level of psychological care that ostomates require is well researched, with issues of body image, physical body changes, odour, noise, loss in role and purpose, and sexuality all to contend with now that they have a stoma (6). These common issues for ostomates are also often accompanied by recovering from surgery, with lack of sleep, pain management, poor appetite, nausea and wound management resulting in complexity of their care management plan. For some the diagnosis and treatment of their cancer is another major part of psychological issues they have to contend with.

This combination of issues is often heightened with the reality hitting them more on returning home for the first time. But each patient’s journey and reality are different, and that non-judgemental nursing manner at times does get tested. The complexity of issues in caring for ostomates is not something that is new and is well acknowledged in the profession. But what I do feel isn’t acknowledged so much is what I call the grey area that lies between STN and Social Worker/Counselling roles. As I have gained more confidence in my role and therefore having patients gain more confidence in me as a STN, I find myself more and more in this grey area feeling that I am not professionally skilled, not being a trained counsellor to deliver the level of support some ostomates require. Some of their realities and situations are very complex, as they can be dealing with multiple issues that if not overcome will affect their quality of life long term.

A new ostomate will often require help dealing with issues that can lead to low self-esteem and isolation, with some having little to no social support as friends and family sometimes become estranged not knowing what to say. It may also be help needed with the acceptance of a palliative or terminal care diagnosis.

This is a tough role for any health professional, but more so, I feel without the skills of being a trained counsellor. Some would say the answer is easy, refer them on to the appropriate service or get them to access the support from a private counsellor. Yes this is a reality, but for some they do not want to be part of the Cancer Society or someone labelled as requiring counselling. An ostomate can feel comfortable with the rapport built with you as their STN, trusting you and so see you as providing the level of psychological support they need. So do you just step away from that aspect of their care, feeling that the support they need to step over this hump is not within your skill level or possibly out of your scope of practice? Or do you remain in this grey area supporting them the best you can, mainly by listening and providing what self-learnt motivational interviewing skills you have, hoping to help them reach the goal of adaptation of life with a stoma, in a more positive light, but then risking finding yourself completely emotionally drained by the end of some weeks, and having feelings of failure as you feel you have not provided the level of support they require?

Acknowledging the need to care for my own psychological health has been a growing part of my reflective practice in the past year. The episode of care that strongly highlighted I needed to do something about this, and again not brush it under the rug, was that of a 49 year old female, who for confidential reasons I will refer to as Emma.

Emma has one more chance at beating her extensive cancer, one more chemotherapy drug to pin all her hope of survival on, a drug that pre surgery she developed cardiac related side effects to. Her surgery which was primarily to remove two large ovarian Krukenberg tumours resulted in the formation of an unplanned ileostomy and right Hemicolectomy. Her fight with cancer started in July 2017 when her primary caecal tumour was diagnosed, following admission to hospital with abdominal pain and fatigue. Emma's stoma sits high up on the right upper quadrant of her abdomen in a deep crease. It protrudes slightly with the spout pointing down at 3 o'clock. The main contributing factor to Emma's reluctance to complete her stoma cares is the result of her waking up to having a stoma she didn't expect. She voices her hate for having it. Her confidence of managing her stoma independently does fluctuate as she may have to change her pouch only three times a week, and then sometimes twice in an hour, which knocks her confidence quickly. Emma constantly voices the feeling of life being unfair, with days where she has no positive outlook on anything in her day to day life. She has every right to feel this way. Some days she just feels she is waiting to die. Her main worry is her two children. This social dilemma, now involving the Hospice Social Worker and Lawyer to support her, is the most unfair part of her circumstance. It is possible that Emma's two children aged 9 and 12 will not only be left without their mother, but no close family members to foster them. Emma becomes tearful easily when thinking and talking about this, with voiced feelings of life being utterly unfair.

With Emma's stoma being problematic, the input she required from me as her community STN was high. Visits were never just the practical supervision of reviewing her stoma cares to support her in managing her stoma cares independently, it was the social aspect of Emma's care that for her was more the priority, and therefore required the most time.

Quickly that patient nurse rapport grew, and more time was required to allow her worries to feel heard and listened too, especially with Emma initially accepting no additional support services. I quickly felt I could not provide the support she needed, even after the 45 minute phone calls about visiting later in the day, I didn't have the answers, or the questions to help support her through this time of grief and adjustment. I would leave her home feeling I was not meeting Emma's holistic needs, therefore not providing her with the care she deserved. Yes I could allow her to express her feelings and allow her to feel heard, but in this circumstance I did not feel this was enough support to address her psychological needs and mental wellbeing. Yes, Emma did not accept extra support from services, being in a sense of denial but it was not ethical for me to avoid these important topics for her just because I did not feel I had the skills to deal with them. So you do the best you can. But at what psychological toll does this take with each time leaving her home feeling she deserves and needs more from me. Initially, it was tears. Then planned weekends of getting away with friends on new adventures, made me feel that I was attending to my emotional wellbeing, and therefore managing this work stressor. But this feeling became more and more short lived, feeling drained and empty emotionally at the end of more weeks. After all this was one of many patients under my care, all equally deserving of my attentiveness and support.

I identified Emma's main priority as getting support around her mental wellbeing, support to help her explore any options around her children's potential future care, so that she could make better informed decisions. This then would hopefully allow her the time and energy to concentrate on fighting her cancer, not just the unfairness of her situation. I carefully needed to try and get Emma to see that having a Social Worker involved is her best bet at getting the outcome she wants if she does not survive this fight with cancer. This is where this case study ends with Emma gaining further support, but still fighting with the unfair circumstance of her children's welfare while fighting her cancer.

In this situation does anyone have the tools that would help Emma to change her outlook? Is it a matter of acknowledging as a health professional that there are situations we cannot fix, and accepting this? I definitely found myself at a point that I needed to change something to allow myself to remain true to who I am as a nurse and individual, or continue to risk moving towards psychological burn out.

Enter a six week mindfulness and meditation course. This provided me with an introduction into helping me to stay in the present moment, and not allowing myself to be distracted by past and future events that cause negativity. To accept things for what they are, and learn to be grateful. Weekly podcasts with exercises aided me to put these learnt skills into practice and with the objective of them becoming a habit. Instantly the benefit of this practice became apparent in creating a positive effect on my working day. At times of feeling overwhelmed and stressed I now use one of a few skills to bring me back to the present moment as a distraction to my busy mind, also helping to switch off that stressed sympathetic 'fight or flight' response.

The introduction of mindfulness-based stress reduction (MBSR) programmes is one way that the NHS is helping address the work-related stress and burnout in the nursing profession. It is not a new realisation that the level of compassion and empathy that is required as a fundamental part of a nurses' daily delivery of care, is resulting in compassion fatigue along with related physical health issues (3). With patient satisfaction linked to the level of compassion delivered, this fundamental skill is one that affects both providers and service users. Caring for those that are traumatised or suffering can naturally lead to compassion fatigue as a consequence of stress (4). Ostomates in my view fit into this category, as a group of patients that often use words of vulnerability to describe themselves. An increased sense of self-compassion, self-acceptance and self-care were common themes provided in feedback from the MBSR programmes delivered to nurses. And with resilience to stress, burnout and emotional exhaustion being seen by practicing self-compassion (5), mindfulness is indeed a positive step towards reducing stress levels and compassion fatigue. Furthermore the enhancement of traits of self-compassion and empathy for others proves satisfying as patients feel increasingly listened to and cared for.

Emotional hygiene is a concept that was introduced to me while researching for this journal article and one that I would like to briefly introduce to you. I believe it supports this topic of healthy psychological wellbeing clearly and really made me ponder more about why we don't inherently look after our emotional wellbeing as we do our physical.

How do we practice personal emotional first aid? We instinctively know that for a physical wound to heal we need to care for it, so why then do we not have the same response to an emotional wound? And why is it that we generally spend more time and attention attending to our oral hygiene, than our emotional hygiene? I recently listened to a Ted Talks – A Case for Emotional Hygiene (7), which caused me to reflect on this and sadly was not shocked to learn how the habit of ruminating (playing a thought over and over again) negatively impacts on our health to the same level as smoking. Stopping those negative thoughts we have around failure and the negative things we say to ourselves when we are at our most vulnerable, is an important starting point of practicing emotional hygiene. Those negative and unhelpful things we wouldn't say to other nurses, so why do we say them to ourselves. By building these new healthy habits, the objective is that when driving away from a difficult patient visit, one's self-esteem is cared for, not damaged by negative thoughts.

Building emotional resilience to thrive and extend your life is about protecting your self-esteem, battling the negative thinking, and changing the responses to failure. My new 12 month goal is to be a STN thriving with emotional wellness, so this group of vulnerable patients continues to get the care and support they require, without it taking an emotional toll on my wellbeing. Without more practice in attending to my own emotional hygiene, I know I cannot continue to provide the level of psychological support ostomates require. So to care for my own psychological health is caring for my patients. Allowing myself to be emotionally supported to prevent burn out from this complex role, that is far more than just putting a bag on.

I acknowledge and support that we will all have our own ways in how we deal with these more challenging patient episodes. But I challenge you not only to step back and look at what you are doing for yourself to protect your own psychological wellbeing, but to allow time each day to attend to your own emotional hygiene. After all I believe putting yourself first to achieve this does not make you a nurse that cares less, but a nurse that cares more, being a nurse who can constantly care for patients at a high standard by caring for themselves. Be accepting that some days we cannot expect ourselves to meet the complete psychological needs of our patients and that this isn't to be seen as failure to care. Give your emotional hygiene the time that it deserves for your own wellbeing.

My objective in writing this article was not to provide answers but to open this topic up for conversation, potentially exposing that aspect of care as a STN that I believe is not well discussed or resourced. With the acknowledged complex care required to meet the needs of an ostomate's psychological wellbeing, why is there not more education around this topic to develop and support the skill base in helping to address this, while remaining to care for our own psychological wellbeing?

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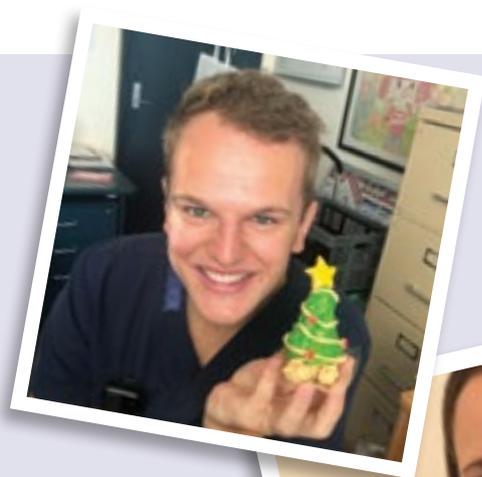
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Phosphate Enema through Colostomy

Pravin Deo

Colorectal Nurse Specialist

Counties Manukau DHB



BACKGROUND

According to Pare, Ferarazzi, Thompson Irvine and Ranee (2001), the number of colostomates who suffer from constipation is similar to that in a general population, which is around 27%. Andromanakos, Skandalakis, Troupis and Filippou (2006) put this figure at between 2-20% in the general population. Amongst elderly people living in a care home the rate of constipation is 50–75 percent (*Canadian Agency for Drugs and Technologies in Health, 2014*). In a general population including colostomates, bowel movement varies from three daily to three times weekly (Emmanuel, 2004 as cited in Burch 2014, pp. 449). Constipation is often the result of an unbalanced diet, too small an intake of food or liquids or side effects of certain medications (The United Ostomy Associations of America, 2004).

For colostomates, it could be suggested that the first line of treatment is to ensure an adequate fluid and fibre intake (Plant & Brierly, 2001). Laxatives may be required to treat constipation in those who do not respond to a healthy diet (Nazarko, 2006). However, individuals with a colostomy should only take laxatives following a consultation with a doctor (The United Ostomy Associations of America, 2004). While oral laxatives are generally effective and given in the same way as to a person without a stoma, giving enemas and suppositories need different management as stomas do not have a sphincter (Burch, 2013), and therefore, spillage during instillation and ineffective occlusion of lumen following it are two major difficulties faced (Ray & Mcfall, 2010).

CONTRAINDICATION

- Do not use in patients with congenital mega colon, bowel obstruction, congestive heart failure, low sodium diet, nausea and vomiting (MIMS (NZ) Limited, 2017). Precautions are also required for patients with renal impairment, electrolyte disturbances pregnancy and lactation (MIMS (NZ) Limited, 2017), as well as in patients with diverticulitis, recent colorectal surgery, crohns disease, ulcerative colitis or known allergy to phosphate or latex (National Health Standard Wirral Community, 2013). Refer to manufacturers guide for adverse reaction and drug interaction before administering a Phosphate enema.
- Coggrave (2008) and Coggrave et al. (2009) explain that large volume enemas are not suitable for use in patients with neurogenic bowel and spinal cord injury as part of their regular bowel management programme because the patient may not be able to retain the enema for it to be effective, over distension of the bowel may stimulate Autonomic Dysreflexia or cause trauma.
- Do not use phosphate enemas in compromised clients, such as those who are elderly or debilitated or have advanced malignancy (Sweeney et al 1986 & Norton 2006)

PATIENT PREPARATION

- Introduce yourself to the patient and explain your role
- Identify the patient as per your clinical guideline
- Explain the procedure to the patient including the reason for the procedure and any risk or benefit.
- Obtain valid informed consent and document in patient's health record
- Prepare necessary equipment
- Before you give a fleet enema through the colostomy, make sure you find out whether it is a loop colostomy or an end colostomy. In the case of a loop colostomy make sure you have identified the distal end and the proximal end of the stoma. This could be done by digital examination of the colostomy. Digital examination and Fleet enema through a colostomy should only be done under the guidance of a doctor, a credential registered nurse or a stomal therapist in a Hospital, Emergency Care Unit, Outpatient Clinic or General Practitioners (GP) Clinic. Fleet enemas should be prescribed by a doctor or Nurse Practitioner and indication for use clearly documented in the patient's record prior to administration.

PATIENT'S POSITION

- This procedure can be done while the patient is sitting up or lying semi fowlers. Assist the patient to turn on his left side or appropriate side to allow easy access to the colostomy.

DIGITAL EXAMINATION

- Wear glove, lubricate your finger with water based lubricant and slowly advance your index finger into the stoma lumen (not going beyond abdominal fascia) to check for any blockages, find the direction of the bowel lumen and mobility of skin and fascial ring (Butler, 2009; Colwell et al., 2004).

PHOSPHATE ENEMA

- Apply two piece clear drainable bag for observing the stoma and output. Take off the pouch leaving the base plate.
- Lubricate Foley catheter (14-16 Fr) and pass gently beyond the parietal wall into the colon, under the guidance of your little finger through the stoma (Ray & Mcfall, 2010). If it is a loop colostomy then make sure that the Foley catheter is passed through the proximal end of the colostomy for constipation management. Phosphate enema may also be administered (in some cases) to cleanse the distal bowel of mucus buildup for colostomy patients, in which case the enema needs to be given through the distal lumen of the loop colostomy. Your doctor should clearly

document the indication for phosphate fleet and in case of loop colostomy, clearly document which end of the colostomy is to be used for phosphate fleet.

- Use of a catheter allows higher instillation of the enema into the colon and thus, less chance of seeping out before becoming effective (Burch, 2013). Use the catheter with caution to ensure the bowel is not damaged (Burch, 2013). Do not force if the catheter does not pass through the lumen with ease.
- Inflate the balloon of the catheter and then pull up slowly until the balloon snugly fits against the parietal wall (Ray & Mcfall, 2010). (Fig. 2)
- Use 10mls of normal saline to inflate Foley catheter 14-16fr (Covidien, 2012).
- Administer the Phosphate enema through the catheter (Fig. 3)
- On completion of administering the enema clamp the outlet (Ray & Mcfall, 2010). (Fig. 4)

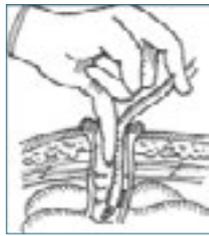


Fig. 1

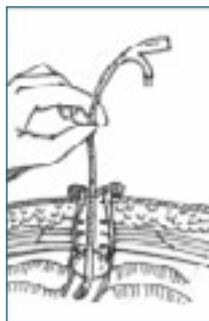


Fig. 2

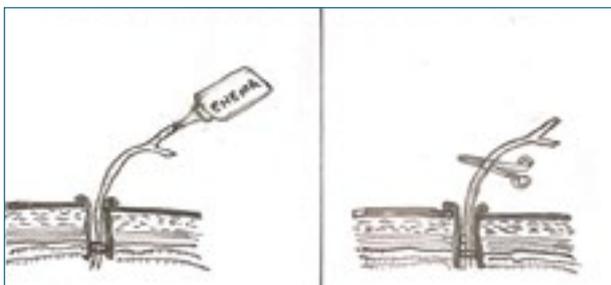


Fig. 3

Fig. 4

- After 10 minutes deflate the balloon and remove the catheter (Ray & Mcfall, 2010)- (fig. 5)
- Reapply the stoma pouch immediately after removing the catheter to avoid spillage as the effect of a fleet Phosphate enema is instantaneous.
- Empty the stoma content in the toilet and document clearly the volume and consistency of the stoma output.



Fig. 5

NURSING CARE

- Wait with the patient to monitor the effects of the enema and document the outcome in the patient's notes
- Monitor the patient for any signs of distress, bleeding from the colostomy, dehydration, abdominal pain, abdominal cramping, and seek medical advice if any of these signs are present.

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Magic Max - A case study in the use of convexity in babies with an ostomy

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ABSTRACT

The pre or post natal delivery of a diagnosis of congenital abnormality in a baby is a sudden, disruptive assault which shatters the normal expectations of a healthy infant.

Congenital rectal duplication cysts are a rare abnormality, which account for <5% of all gastro-intestinal tract duplications⁽¹⁾.

This case study is presented because of the condition's rarity, its unique presentation, the complexity of management and the impact these events had on the family unit. Despite the sensitivity of the issues involved with the birth of a baby with a congenital abnormality, Baby Max's parents have given their consent for his information and pictures to be used. This case study follows my involvement with Max and his family over a 7 month period in early 2016.

WHO IS MAX?

Baby Max was born to first time parents Kay and Richard, at full term and after a routine pregnancy. After an uneventful delivery Max and his mother were discharged from their tertiary place of delivery to a primary care facility.

FIRST PRESENTATION

Baby Max first presented 24 hours post-delivery to the emergency department with bilious vomiting. Meconium had been passed prior to this presentation. An upper GI contrast study showed a dilated loop of colon. Once both the study and Max had been reviewed by a Consultant the dilated loop was deemed to be of no immediate significance. Baby Max was discharged back to his primary health care facility with a plan for review at a later date.

SECOND PRESENTATION

Within 24 hours Max re-presented with restlessness, difficulty feeding and bloody vomits. Investigations during this second presentation included:

- USS
- MRI
- Micturating Cysto-Urethrogram and a contrast enema.

DIAGNOSIS

The USS revealed a large pelvic cyst blocking Max's bladder and partially obstructing his bowel. A diagnosis of duplication cyst was confirmed.

FIRST SURGERY

Max underwent a cystoscopy followed by laparotomy with a defunctioning double-barrelled sigmoid colostomy the day after diagnosis. The plan was for resection of the duplication cyst when Max was around 11 weeks old and then further surgery at a later date to reverse his stoma.

WHAT IS A DUPLICATION CYST?

Neonates presenting with a perineal mass are uncommon⁽⁴⁾. When encountered, most neonatal perineal masses are likely to be anorectal malformations, teratomas, rectal prolapses or lastly, a rectal duplication cyst.

First characterised in 1937 by Ladd,⁽³⁾ duplication cysts can occur anywhere in the gastrointestinal tract. This rare condition is sparsely documented. Comprising <5% of all gastrointestinal duplications, rectal duplication cysts are one of the rarest form of duplication occurring in 1:10,000 live births. Associated congenital abnormalities are present in 50% of cases and can include bladder exstrophy, urethral duplications, fistula, and vertebral defects, rarely cardiac malformations are also present.⁽¹⁾

Rectal duplication cyst presentation can occur in adulthood, but most commonly is diagnosed before the age of two years. The cyst usually presents as a gradually enlarging perineal / parasacral mass. Enlargement is due to the contained secretions from the cyst's epithelial lining. Rectal duplication cysts may, initially, be misdiagnosed as haemorrhoids, prolapse or a rectal polyp.

Embryological theories for enteric duplications include:

- Incomplete separation of the notochord from the endodermal tube
- Defects in re-canalization
- Partial caudal twinning
- Persistent epithelial buds
- And defective adherence of the endoderm to the notochord during embryonic development.^{(5) (6)}

Ladd and Gross⁽⁷⁾ maintain that to classify a lesion as duplication it should have at least two of the following criteria:

- contiguity and strong adherence to some part of the gastrointestinal tract
- a smooth muscle coat
- a mucosal lining consisting of one or more types of cells normally found in the gastrointestinal tract.

Rectal duplications can be anterior, however, are more commonly posterior. Further classified as type 1, cystic or type 2, tubular, they are most commonly cystic and will not communicate with the rectum.⁽⁸⁾

The management of rectal duplication cysts includes early and complete surgical excision. The aim of treatment is to relieve symptoms, restore the anatomy, preserve anorectal function, and prevent the risk of adenomatous transformation into a carcinoma.⁽⁹⁾

MY FIRST ASSESSMENT OF MAX

My first assessment of Max was at 17 days of age and 2 days post discharge from hospital.

My findings included:

- A healthy colostomy and mucus fistula
- Normal output for a breast fed baby
- Peristomal skin slightly irritated. This quickly resolved with the discontinuation of alcohol remover wipes
- Baby Max was alert and feeding well
- Producing fountains of urine especially when out of a nappy!

My involvement with Max to this point was routine. In all aspects Max was growing and achieving his milestones.

ASSESSMENT OF FAMILY UNIT

Kay was managing Max's colostomy care remarkably well. She acknowledged feeling tired and emotionally fragile due to Max's diagnosis. The need to surrender her newly born son for surgery and the need for further surgery were taking an emotional toll. Richard was managing some of Max's night care and their extended family were very supportive.

Prior to Max's birth, Kay had secured what she described as her dream job. She described having to work hard in her industry to get to where she was. She had negotiated 6 months maternity leave, and had investigated childcare options suitable to her location and hours of work. She was proud to be able to support her husband in his job as a youth worker for troubled teens, and we had many conversations over the duration of my involvement with Baby Max about how it was important for him to continue in that job. Kay's return to work plans were no longer feasible. It was possible that the family could face some financial challenges as a result of meeting Max's care needs.

The diagnosis of any congenital abnormality in an infant will disrupt normal parental expectations. While coping with the normal challenges / issues involved in transition to parenthood, parents of an infant with a congenital abnormality face increased risks associated with poor parental bonding, feeding disruption, anxiety and depressive disorders.⁽¹¹⁾ Diagnosis of a congenital abnormality is also often accompanied by unplanned medical, financial, social and emotional demands. Maternal distress may be demonstrated as impaired bonding, post-partum depression, or anxiety and decreases maternal milk production leading to feeding difficulties.⁽¹³⁾

The level of distress that develops is directly related to the extent of social support available, the extent of the infant's abnormality and the level of participation that the mother was able to contribute to the infant's care. Kucova⁽¹⁴⁾ documented that mothers identified the support of nurse led interventions, the nurse's ability to share accurate, understandable information and the nurse's encouragement of their efforts with child care as key factors in reducing their stress, anxiety, and feelings of depression.

My involvement with Max and his family in the first 10 weeks after discharge was routine. In all aspects Max continued growing and achieving his milestones. He developed some undermining of the appliance along the healed suture line about 2 weeks after discharge. This resolved with a small strip of Eakin seal placed over the suture line. Kay continued to benefit from confirmation that her care of Max's colostomy was appropriate. She would often ring to discuss small deviations from the previous day. Encouragingly, these phone calls became less frequent. She verbalised her expectations that his surgical treatment would progress in a straightforward fashion and be successfully completed within a 6 month timeframe.

SECOND SURGERY

At 10 weeks of age Max was admitted for his second surgery. He underwent a laparotomy, excision of the duplication cyst, full thickness low anterior anastomosis with a defunctioning loop ileostomy.

Max's ileostomy was to prove significantly more problematic than his colostomy had been (see Fig 1).

First Ileostomy Assessment:

- Normal output consistency and volume
- The ileostomy appears normal in fig 1, it seems well spouted however this was not a reality. The ileostomy was actually mushroom shaped with a narrow exit point from the abdomen and a bulbous end
- The peristomal skin was widely eroded, raw and painful for Max
- A peristomal crease from the stoma, extended laterally to the left lower abdomen. This crease became more pronounced with Max's leg movements
- At this stage a flat pouch was in use



Fig. 1

The overwhelming difference between this contact and my previous one with the family was Kay's anxiety and stress levels. Having so competently and with great resilience managed the colostomy Kay was now attempting to manage short pouch wear times, leaking pouches, and changing a pouch on a baby with painful, eroded skin. Max was becoming an increasingly mobile target for pouch changes.

Kay described not being able to leave the house for fear of having to change Max's pouch in a public rest room. She was now house bound, living a life ruled by Max's stoma care needs. Pouch changes were becoming increasingly traumatic for both Kay and Max.

Max's ileostomy defeated all cross supplier product combinations of flat pouches, seals and accessories.

Frequently, Stomal Therapy practice requires expert assessment, problem solving, in-depth product knowledge, and taking small steps towards the solution.

At this stage I felt thwarted and doubted my ability to find a successful solution. The possibility of using a convexity pouch on a baby was becoming an option to be considered, however I had never used convexity on a baby and had some uncertainty on account of this.

An extensive literature search confirmed that there was paucity of information around the use of convexity in paediatrics, nor valid practice guidelines for managing paediatric stomas with convexity.

Lacking any researched solution I turned to my peers. Although none of them had used convexity on a baby we did find the Eakin Pelican paediatric convex pouch (Fig.2). After obtaining samples and assessing the pouch's convexity profile, rigidity and depth, my confidence in using it increased. At the least I felt it would do no harm.



Fig. 2

THE OUTCOME

Sadly I don't have pictures of the dramatic outcome achieved once we commenced use of the Eakin Pelican paediatric convexity pouch. Within one week Max's skin had completely healed. Without random unpredictable leaks, wear times of 48 hours were being regularly achieved. Kay and I considered this very acceptable. Kay's confidence had returned and she was enjoying venturing out of the house with Max; she loved sharing anecdotes about him. Increasingly she began to talk of her family plans beyond the immediate needs and timeframes of Max's current care.

She continued to benefit from the reassurance and confirmation that the care she gave Max was appropriate.

CONCLUSION

Max's continued journey was uneventful, and he underwent reversal of the ileostomy several months later. He continued to use the Eakin Pelican pouch until that time. He is now a happy & healthy pre-schooler.

Max's care gave me an appreciation that not all solutions will be immediately found in research, many begin in the combined knowledge of colleagues, or are new developments. Stomal Therapists are in a unique position to offer the expert assessment, continuity of care and persistence required to build towards that solution.

The professional maturity and culture that allows us to acknowledge, that as individuals we may not always have the solution promotes a team culture of information and skill sharing. This can be critical to achieving a positive patient outcome.

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Those troublesome stomas!

Jackie Hutchings
Stomal Therapist
Nurse Maude



I have always been lucky to practice in areas where there have been no barriers to the use of any product if I have a clinical reason or need. I know that in some regions in New Zealand you do have restrictions in place, so options can be more limited. I do like to trial new products that come to the market so I know their applications for use.

This year has been particularly bad for two things with stomas and I am going to talk about each of them.

I would love to hear from others how they treat similar cases as the best way to learn is from each other's experiences.

COMPROMISED STOMAS

Firstly, I do not think I have seen as many compromised stomas in the initial post-operative period and they range across most surgical teams and the age range is from 6 – 86, so paediatrics included. In most cases these patients have gone home with these stomas, having to care for something that is hard to see as often the stoma is below skin level but also the smell can be overwhelming making the stoma much harder to come to terms with.



Fig. 1



Fig. 2



Fig. 3



Fig. 4



Fig. 5



Fig. 6



Fig. 7



Fig. 8

All these photos were taken in April and May this year with the most unusual being Fig 7 which is an existing urostomy that ended up becoming compromised following further bowel surgery. It was very cold to touch. Fortunately, the majority are colostomies so even when the patient is left with a retracted stoma hopefully they will end up with a firmish output and they shouldn't have ongoing leakage issues.

Surgeons always come up with reasons why it happened such as obesity or the patient being medically unwell so they want to get in and out as quickly as possible, but this doesn't take into account how the patient sees their new stoma when they have leakage while their output is loose or the ongoing smell which can carry on for weeks until all the necrotic tissue has sloughed away. This can also cause stress and strain with relatives in the home as they must put up with it as well.

I always use stomahesive or adapt powder on these stomas as it does help debride and deslough more quickly and most them will be on some form of convexity especially in the early days. Patients use neutralizing air fresheners, but these often aren't enough. The answer would be revision but our surgeons don't usually see this as an option even when the stoma is deeply retracted with only some strands of slough visible in the base – but if the stoma is working that means it is okay!

PERISTOMAL ULCERATION



Fig. 1

Fig. 2

This patient has a urostomy and unfortunately I didn't get a photo when it was at its worst when he had 3 ulcers with one at 12 o'clock as well. He did have a staphylococcus infection and this was treated for three weeks. I was fortunate that he was in a medical ward at the time and they were happy to treat with a long course of flucloxacillin. The main issue I often have is that the GP will only prescribe 5 – 7 days of antibiotics and it is not enough. These photos were only taken 4 days apart but there is already progress in Fig 2. We did treat the surrounding skin with betamethasone lotion as it was quite shiny and red at times. The ulcer was treated with Aquacel rope and tegaderm over the top giving the bag something to adhere to. We changed the bag every second day.



Both of these patients were ileostomates with inflammatory bowel disease who developed these areas a few months post operatively. Swabs were done, and both were started on antibiotics and healed with stomahesive powder and comfeel transparent ulcer dressing on them, but I still think there is an IBD component to them. One good thing is that they both have reasonable stomas!



Fig. 1

Fig. 2



Fig. 3

These three photos were taken only days apart and after I saw it the third time I contacted his gastroenterologist as I suspected it might be pyoderma gangrenosum as it had also become quite painful. He has a history of Crohns. His specialist immediately organised an urgent ileoscopy. He has been started on prednisone and methotrexate. He is for proctectomy as it is believed that getting rid of active disease may help settle the pyoderma. He has been started on topical pimarufucort both for the steroid effect and to aid with hypergranulation. Tacrolimus was considered but as it is not funded by Pharmac it was too expensive.

ULCERATIVE COLITIS

This patient had Ulcerative Colitis and developed quite a significant ulcer before he called us. To start with I treated it with Hyalo4 control spray which contains hyaluronic acid and metallic silver and then Hyalo4 Regen dressing to the ulcer bed. The ulcer started healing in quite quickly as it was deep but once it was more surface it was also extremely vascularised (fig 1) and started to overgranulate (fig 2). I changed the dressing to Aquacel rope and tegaderm and changed him to a shallow convexity instead of the deep that he was using. It continues to improve.



Fig. 1



Fig. 3



Fig. 2

As I said at the start I would really like to hear what other things you have tried and found to work with similar issues as these are quite common.

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