

Ostomy Education Table

Stoma Types





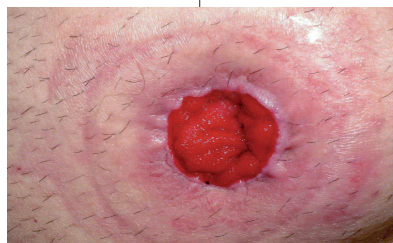



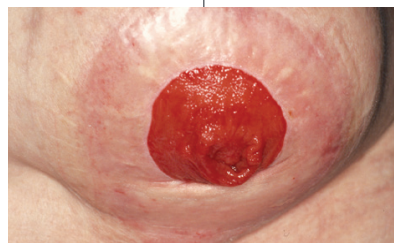
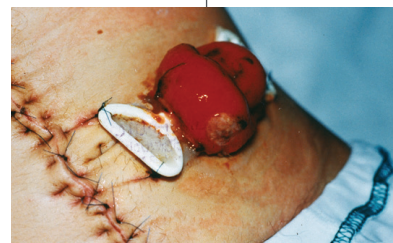

Protruding		Flush/Retracted					Other Stoma Types			
Firm Abdomen	Flabby Abdomen	Flush	Slightly Retracted or Recessed	Retracted	Scars	Skin Folds	High Output Stoma	Parastomal Hernia	Loop Stoma with Rod	Prolapse
										
Products: SenSura® Mio, SenSura®	Products: SenSura® Mio, SenSura®	Products: SenSura® Mio or SenSura®	Products: SenSura® Mio or SenSura®	Products: SenSura® Mio or SenSura®	Products: SenSura® Mio or SenSura®	Products: SenSura® Mio or SenSura®	Products: SenSura® Mio	Products: SenSura® Mio	Products: SenSura® Mio or SenSura®	Products: SenSura® Mio or SenSura®
System: One-Piece ¹ Two-Piece Click ² Two-Piece Flex (Adhesive Coupling) ³ Brava® Accessories ⁵	System: One-Piece ¹ Two-Piece Click ² Two-Piece Flex (Adhesive Coupling) ³ Brava® Accessories ⁵	System: One-Piece ¹ Two-Piece Click ² Two-Piece Flex (Adhesive Coupling) ³ Brava® Accessories ⁵	System: One-Piece ¹ Two-Piece Click ² Two-Piece Flex (Adhesive Coupling) ³ Brava® Accessories ⁵	System: One-Piece ¹ Two-Piece Click ² Two-Piece Flex (Adhesive Coupling) ³ Brava® Accessories ⁵	System: One-Piece ¹ Two-Piece Click ² Two-Piece Flex (Adhesive Coupling) ³ Brava® Accessories ⁵	System: One-Piece ¹ - for the flexibility Two-Piece Click ² or Two-Piece Flex (Adhesive Coupling) ³ - used with Brava® Accessories ⁵ to fill in at folds	System: One-Piece High Output Pouch Two-Piece Click with High Output Pouch or Ileo Night Pouch Brava® Accessories Two-Piece Flex with High Output Pouch	System: One-Piece ¹ Two-Piece Flex (Adhesive Coupling) ³	System: One-Piece ¹ Post-Op Pouch Two-Piece Flex (Adhesive Coupling) ³	System: One-Piece ¹ Two-Piece Flex (Adhesive Coupling) ³
Barrier type: Standard Wear Xpro (Extended Wear) ⁴	Barrier type: Standard Wear Xpro (Extended Wear) ⁴	Barrier type: Standard Wear Xpro (Extended Wear) ⁴	Barrier type: Standard Wear Xpro (Extended Wear) ⁴	Barrier type: Standard Wear Xpro (Extended Wear) ⁴	Barrier type: Standard Wear Xpro (Extended Wear) ⁴	Barrier type: Standard Wear Xpro (Extended Wear) ⁴	Barrier type: Standard Wear (High Output) Xpro (Extended Wear) ⁴	Barrier type: Standard Wear	Barrier type: Standard Wear Xpro (Extended Wear) ⁴	Barrier type: Standard Wear Xpro (Extended Wear) ⁴
Flat	Convexity level: Soft Light Deep	Convexity level: Flat Soft Light	Convexity level: Light Deep	Convexity level: Light Deep	Convexity level: Flat Soft Light Deep	Convexity level: Flat Soft Light Deep	Convexity level: Flat Soft Light	Convex Flip	Flat	Flat

Photo Courtesy of the Cleveland Clinic Foundation, Cleveland, Ohio, USA

Footnotes:

- ¹ One-piece Systems - are low-profile, ultra-flexible and may be beneficial for patients with limited dexterity.
- ² Two-piece Click Systems - allow the patient to change the pouch without changing the barrier. These systems offer patients access to the stoma so the stoma is visible when applying the barrier.
- ³ Two-piece Flex Systems - utilize adhesive coupling technology rather than a plastic locking ring to attach the pouch to the barrier. Two-piece Flex Systems offer the same flexibility as a one-piece system and are ideal for active lifestyles.
- ⁴ Xpro (Extended Wear) barriers offer increased adhesion and erosion resistance for extra protection against urine or loose, liquid stool.
- ⁵ Brava® Accessories - may be used as needed to fill in and caulk uneven skin surfaces and add convexity to the pouching system and to manage peristomal skin irritation.

- Brava® Elastic Barrier Strips - Curved, Y shape, Straight, and XL size options provide a range of shapes for a custom fit to support the outer edge of the ostomy barrier by providing additional adhesion to the intact skin.
- Brava® Protective Seal - Moldable, extended wear design protects against leakage and provides skin protection. Protects peristomal skin, provides a seal over creases, and stays in place.
- Brava® Moldable Rings - Alcohol-free, pectin-based rings used to fill in uneven skin surfaces due to skin folds, scarring and/or irregular body contours, thereby creating a level pouching surface. Can be used under the barrier to create a tight seal between the barrier, stoma and skin or to build flexible convexity around the stoma. Ultra-durable formula won't dissolve when exposed to liquid output.
- Brava® Ostomy Support Belt - This belt relieves the heavy sensation of hernias and may help prevent hernias post-operatively. Made with comfortable and breathable fabric, stretchable to fit body contours, intuitive pocket closure, and includes a silicone grip to prevent sliding and rolling.
- Brava® Belt - Elastic belt made from soft, comfortable material. Can be used with all Two-Piece Click² systems and convex barriers.

- Brava® Strip Paste - Alcohol-free, pectin-based strips used to fill in uneven skin surfaces due to skin folds, scarring and/or irregular body contours, thereby creating a level pouching surface. Can be used under the barrier to create a tight seal between the barrier, stoma and skin or to build flexible convexity around the stoma.
- Brava® Paste - Used to fill in uneven skin surfaces due to skin folds, scarring and/or irregular body contours, thereby creating a level pouching surface. Alcohol-free and sting-free.
- Brava® Protective Sheet - Secure and flexible skin barrier sheet for total skin protection around stomas, draining wounds, and other areas subject to irritation.
- Brava® Powder - Absorbent, protective powder used with crusting technique. Absorbs excess moisture from the skin surface prior to applying a pouching system.
- Skin Barrier Rings - Soft and flexible pre-cut rings provide extra skin protection and level out skin defects.
- Skin Sealant - Brava® Skin Barrier Wipes/Spray or Prep[®] - Used for providing skin protection under tapes and adhesives. Brava® Spray and Prep wipes or dabber can be used with crusting technique.

ALL COLOPLAST PRODUCTS ARE NOT MADE WITH NATURAL RUBBER LATEX.
Monthly Medicare Allowables

Medicare identifies frequency guidelines for certain supply items manufactured by Coloplast Corp. in coverage policies and articles published by the local Medicare contractors and are available online by searching the Medicare Coverage Database at: <http://cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. These policies may change without notice. Contact your local payer to discuss the frequency at which your supplies can be billed.

Drainable pouches	up to 20/month	Skin barrier wipes	up to 150 per 6 months
Closed pouches	up to 60/month	Skin barrier liquid	2 oz. per month
Urinary pouches	up to 20/month	Skin barrier paste	4 oz. per month
Skin barrier (4" x 4")	up to 20/month	Skin barrier powder	10 oz. per 6 months
Skin barrier with flange	up to 20/month	Ostomy belt	1 per month

Types of Ostomies



Ileostomy

An ileostomy is a surgically created opening in part of the small intestine called the ileum. Ileostomies may be permanent or temporary, depending on the disease process.

The stool can range from a liquid to a pasty consistency, and contains enzymes that are irritating to the peristomal skin.



Colostomy

A colostomy is a surgically created opening in part of the large intestine (colon). Colostomies may be permanent or temporary depending on the disease process. The stool consistency will depend on where the colostomy is located.

- Ascending colostomy: Stool can range from liquid to pasty consistency and may be irritating to the skin
- Transverse colostomy: Stool is somewhat formed
- Descending/sigmoid colostomy: Stool is formed

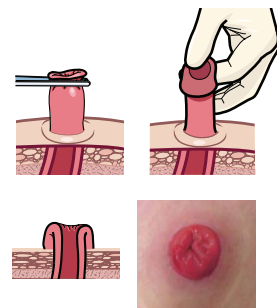


Urostomy/Ileal Conduit

A urostomy/ileal conduit is created from an isolated segment of the ileum. The ureters are surgically tunneled into a small segment of the small intestine (20-25 cm) called a conduit or (i.e. channel or tube).

One end of the ileum is sutured closed and the other end is brought to the surface of the abdomen to form a urinary stoma.

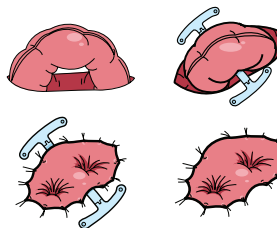
Ostomy Construction



End Stoma

An end stoma is constructed by dividing the bowel and bringing the proximal end through the abdominal wall, everted and stitched to the skin surface of the abdomen.

An end stoma can be in the small or large intestines.

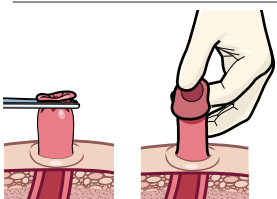


Loop Stoma

A loop stoma can be created in the small or large intestine.

A loop of intestine is brought through the abdominal wall. The exposed intestine is opened and matured into a stoma. A functioning limb (proximal) and non-functioning limb (distal) are created. The functioning limb transports stool and the non-functioning limb can expel mucus.

A plastic rod or tubing may be placed under the loop of intestine to support the stoma on the abdominal wall. The rod is removed per institution protocol or physician preference.



Double Barrel Stoma

A double barrel stoma can be created in the small or large intestine.

The intestine is divided and the two ends are brought through the abdominal wall and sutured to the skin. A skin bridge may separate the two ends of intestine. One stoma is functioning (proximal) and transports stool and one is non-functioning (distal). The non-functioning limb is referred to as the mucous fistula which expels mucus.



Peristomal Skin Conditions



Mechanical Injury

Mechanical injury is peristomal skin damage or skin damage due to pressure, friction, medical adhesives, or removal of the adhesive barrier. Contributing factors include: traumatic removal of the barrier, vigorously scrubbing the peristomal skin and/or a poorly fitting pouching system.

Prevention:

- Gently clean the peristomal skin
- Remove the barrier in the direction of hair growth using the push-pull technique
- Use warm water or adhesive remover to remove the barrier if needed
- Evaluate pouching system to ensure proper fit including any areas of pressure caused by the pouching system

Management:

- Consult with physician or WOC Nurse
- If skin is moist and weepy, consider the crusting technique!



Irritant Contact Dermatitis

Hypersensitivity to chemical agents such as stoma output, soaps and/or adhesives resulting in an inflammatory response. Associated with well-defined erythema, edema or loss of epidermis. Pruritis, crusting, oozing or dryness may be present.

Prevention:

- Measure and cut opening of barrier to the size of the stoma
- Change barrier on schedule
- Change barrier immediately if burning, irritation or signs of leakage occur
- Examine the back of the barrier upon removal for areas of erosion
- Limit the use of products on the skin

Management:

- Consult with physician or WOC Nurse
- Identify the underlying cause
- Use correctly sized barrier and consider using convexity and/or an ostomy belt
- Consider using an extended wear barrier
- If skin is moist and weepy, consider crusting technique!



Allergic Irritant Dermatitis

Immunologic response due to exposure to an allergen. Associated with areas of erythema that may correspond to the shape of the contact surface.

Prevention:

- Limit the use of products on the skin
- Add one new product at a time to assess patient's reaction

Management:

- Consult with physician or WOC Nurse
- Remove known or suspected allergen - change type of pouching system and/or eliminate any unnecessary products
- If skin is moist and weepy, consider crusting technique!



Pyoderma Gangrenosum

Rare inflammatory skin disorder with unknown etiology seen in patients with inflammatory bowel disease or other auto-immune diseases. The lesions are ulcerated with dusky red to purplish margins seen in patients with inflammatory bowel disease or other auto-immune diseases. Lesions can be painful.

Management:

- Consult with physician or WOC Nurse
- Manage the underlying disease and infection per physician order
- Manage ulcer pain per physician's orders
- Consider steroids with physician's orders
- Use a flexible barrier with a gentle adhesive
- If skin is moist and weepy, consider crusting technique!
- Wound care may be ordered by the physician and is determined by amount of drainage and depth of wound



Folliculitis

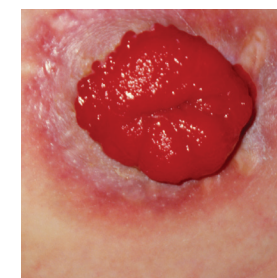
Folliculitis is an inflammation of a hair follicle. It is often caused by bacterial sources such as *staphylococcus aureus*, *streptococci* and *pseudomonas aeruginosa*. Predisposing factors include antibiotic therapy, diabetes and immunosuppression.

Prevention:

- Gently remove the barrier to prevent skin trauma
- Shave hair in the direction of hair growth, but always away from the stoma to avoid nicking or cutting the stoma
- Use an electric razor
- Wash, rinse and completely dry skin before applying a new pouching system

Management:

- Consider adding antibacterial cleansing at pouch change
- Consult with physician or WOC Nurse
- Identify the underlying cause
- Avoid shaving hair in affected area - only clip the hair
- If skin is moist and weepy, consider the crusting technique! using ostomy powder or an antifungal powder (first obtain physician's order/prescription) if a fungal rash is present



Fungal Infection (Candida/Yeast)

Candida is a common skin flora that grows in dark, damp sites such as under an ostomy barrier. The rash starts out as pustules before turning into a raised area with erythema consisting of irregular margins with surrounding satellite lesions. Patients may complain of itching or burning. Predisposing factors include antibiotic therapy, diabetes or immunosuppression.

Prevention:

- Use a properly fitting pouching system
- Eliminate cause of moisture: inspect pouching system for signs of leakage
- After bathing, dry the skin and the pouching system thoroughly
- Assess wear time by examining the barrier for erosion upon removal

Management:

- Consult with physician or WOC Nurse
- Identify the underlying cause
- If skin is moist and weepy, consider the crusting technique using antifungal powder in place of ostomy powder (first obtain physician's order/prescription)!
- Systemic treatment may be prescribed by the physician if more than one body area is involved
- Blood sugar management may also need to be considered



Pseudoverrucous Lesions (Hyperplasia)

Hyperplasia refers to skin maceration due to excess moisture. However, pseudoverrucous lesions are most often seen with urostomies due to the alkaline nature of urinary output. The wart-like lesions are usually caused by urine that remains in contact with the skin for extended periods of time.

Prevention:

- Correctly cut the barrier to the size of the stoma
- Assess for leakage. Examine ostomy barrier for erosion upon removal and adjust wear time accordingly
- Consider using an extended wear barrier
- If stoma is flush or retracted, consider a pouching system with convexity
- Use a pouch that has a built-in anti-reflux valve to prevent urine from washing over the stoma
- Use a bedside drainage system at night

Management:

- Consult physician or WOC Nurse
- Identify the underlying cause
- Modify the pouching system
- Check urine pH to assess urine acidity
- If pH is too alkaline, physician's orders may include applying white vinegar soaks and/or a Colly-Seel®-type barrier to the wart-like lesions until the condition improves *Colly-Seel (Torbot Group, Inc. 800-545-4254)

Stomal Challenges

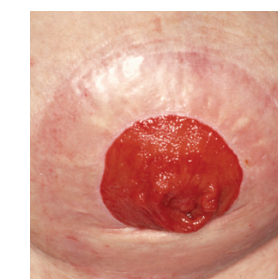


Prolapse

A prolapse occurs when the bowel telescopes through the stoma, causing the stoma to increase in length. It is most common with loop colostomies. Contributing factors include: abdominal wall opening larger than the bowel, increased abdominal pressure and weak abdominal tone.

Management:

- Consult with physician or WOC Nurse
- Instruct patient to avoid weight gain and suggest regular exercise to increase abdominal tone
- Consider the use of prolapse support binder
- Revise pouching system
 - Larger pouch to accommodate increased stoma length
 - Measure stoma base while stoma is protruding at its largest size (sitting position)
 - Cut barrier opening to accommodate stoma at its largest size
 - Use a flexible, flat barrier
- Instruct patient to notify physician for signs and symptoms of obstruction and ischemia

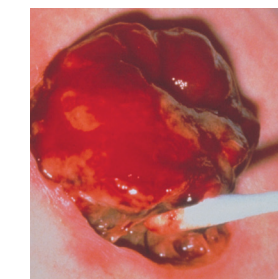


Parastomal Hernia

Occurs due to a weakness in the muscle layer of the abdominal wall, allowing intestine to come through the muscle. Contributing factors include a fascial opening larger than the stoma/intestine, poor muscle tone and placement of the stoma outside the rectus muscle.

Management:

- Consult with physician or WOC Nurse – notify for signs related to hernia strangulation
- Measure the stoma while patient is sitting up and stoma is at its largest
- Use a 1-piece pouching system or a 2-piece adhesive coupling system, which allows flexibility and adapts to abdominal contours
- Consider a hernia support belt for added support
- Instruct patient to avoid constipation and/or excessive weight gain



Mucocutaneous Separation

The sutured junction between the stoma and the skin is called the mucocutaneous junction. When the junction completely or partially separates from the skin, it is called a mucocutaneous separation. Contributing factors include infection, tension on the suture line and delayed healing due to disease process, compromised nutritional status or corticosteroids.

Management:

- Consult with physician or WOC Nurse
- Wound care may be ordered by the physician and is determined by amount of drainage and depth of wound
- Change pouching system as needed to provide wound care



Necrosis

Occurs due to a reduction of blood flow to the stoma affecting stoma viability. Contributing factors include edema of the bowel wall, extensive tension on the mesentery, obesity and too tight or closely placed sutures. Necrosis typically occurs within the first 5 days post-op.

Management:

- Consult with physician or WOC Nurse
- Use a transparent, two-piece pouching system for closer inspection of the stoma
- Size the barrier appropriately to prevent constriction
- Resize the barrier as nonviable tissue sloughs and stoma contracts
- Use Brava® Lubricating Deodorant while necrotic stoma is sloughing off if needed for odor control
- Assess for stenosis as area heals

Footnotes:

† Crusting technique: Creates a protective crust to protect the skin and assist with healing underneath the ostomy barrier by alternating layers of ostomy powder and a protective barrier to the affected peristomal area.

1. Gently clean the skin with warm water.
2. Pat or air dry.
3. Dust the affected area with ostomy powder and gently brush away the excess.
4. Seal in the powder with Prep™ or sting-free Brava® Skin Barrier Spray. Allow to dry.
5. May repeat steps 3 and 4 if necessary.
6. Apply pouching system.

Note: Crusting can also be accomplished without skin sealant. (Simply sprinkle the powder on the affected area and wipe off the excess.)

References:

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