



DEFINITION

“Stoma” is derived from the Greek word for mouth or opening.

“Ostomy” [-suffix] surgically created opening, made to divert the direction of flow of the contents.

THE OSTOMATES BILL OF RIGHTS

The International Ostomates Association has declared a Charter of rights for people experiencing ostomy surgery. Stating, “All shall have the right to a satisfactory quality of life after their surgery”

THE OSTOMATE SHALL

- Be given pre-op counselling
- Have an appropriately positioned stoma
- Have a well-constructed stoma
- Have skilled postoperative nursing care
- Have emotional support
- Have individual instruction
- Be informed on the availability of supplies
- Be provided with information on community resources
- Have post-hospital follow up and lifelong supervision
- Benefit from team efforts of health care professionals
- Be provided with information and counsel from the ostomy association and its members.

Adopted by the United Ostomy Association House of Delegates at the UOA Annual Conference 1977

TEMPORARY OR PERMANENT STOMA

Temporary: To assume the function of elimination of waste, to permit healing or rest the gut or section of bowel

Permanent: To take over the function of elimination of the bowel that has been removed or permanently bypassed.

THREE CLASSIFICATIONS OF STOMAS

Input stomas

Usually temporary and facilitates nutrients being put into the gut.
Examples: gastrostomy / jejunostomy

Diverting stomas

Diverts the contents away from the diseased or damaged gut
Examples: Ileostomy / loop colostomy

Output stomas

Provides an outlet for elimination of body waste, and usually follows excision of an excretory organ.
Examples: Bladder /Bowel

THE INDICATIONS FOR STOMA SURGERY

Congenital

Ano rectal malformation / oesophageal atresia / Ectopia vesicae

Acquired

Radiation fistula secondary to radiation fibrosis / radiation enteritis
Vesico vaginal / recto vaginal fistula

Traumatic

Gunshot wounds / Stabs / MVA

Infective

Inflammatory bowel disease crohns / ulcerative colitis / Diverticulitis / Interstitial cystitis

Neoplastic

Carcinomas of the bowel / bladder

MOST COMMONLY CREATED OUTPUT STOMAS

Faecal:

Colostomy and ileostomy

Urinary:

Ileal conduit /Urostomy and nephrostomy

SITES IN THE GUT [SUFFIX-OSTOMY]

Oesophagostomy

Gastrostomy

Duodenostomy

Jejunostomy

Ileostomy

Colostomy – Caecostomy / Ascending colostomy / Transverse colostomy /

Descending colostomy / sigmoid colostomy

The typical location for a stoma is determined by the anatomic location of the segment to be exteriorized.

The actual site selection is by far the most crucial and is based on the assessment of the patient's anatomical contours.

If the usual site does not provide an appropriate pouching surface, then alternative sites are selected by the stomaltherapist and the surgeon is notified re the location and the rationale.

Siting a patient one needs to know the following

- Provisional diagnosis
- The planned incision
- Proposed stoma
- The stomaltherapist will always sit, stand and lie the patient to obtain the most appropriate site

Factors taken into consideration:

- Locate the rectus muscle
- Ascertain the waistline/ beltline
- Ascertain the hobbies, work, sport and activities of the patients

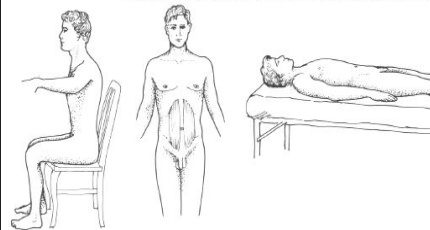


SIT, STAND & LIE THE PATIENT

SELECT SITE : • on apex of subumbilical fat roll
• within the rectus muscle

AFFIX POUCH TO CHOSEN SITE

- Adhesive must NOT encroach incision or umbilicus



When siting a patient **avoid**

- Lower costal margins
- Planned incisions
- Old scars
- Obvious creases
- Umbilicus
- Iliac crests

Special considerations are made re Patients receiving radiotherapy, orthopaedic and neurological patients.

TYPES OF COLOSTOMIES

End colostomy

This is a permanent stoma. There is NO other bowel distal to this mobilized limb

Loop Colostomy

These stomas are usually temporary. There are two openings/ limbs of the same bowel side to side.

They are referred to as the proximal and distal limbs

The proximal limb is the active or functioning limb and the distal limb is the in- active limb.

Divided colostomy

These stomas are situated independently on the abdomen and are usually unable to be brought together at the time of surgery.

Double –Barrel / Mikulicz

This is a divided colostomy, mobilized alongside each other through the same site on the abdomen

FACTORS INFLUENCING STOOL FREQUENCY AND CONSISTENCY

- Site in the colon
- Precipitating condition or disease process
- Previous surgery to the GIT Tract
- Radiotherapy and Chemotherapy
- Medication
- Physical status
- Eating and drinking habits

ASSESSMENT OF A STOMA

Stoma viability

Size - Measure the diameter

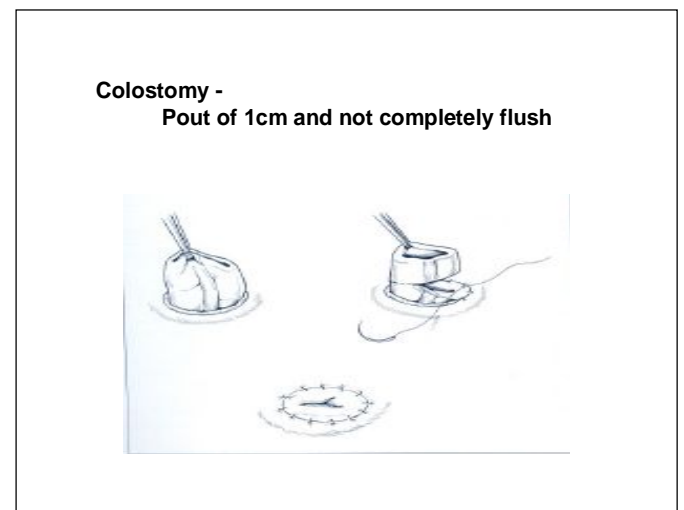
Skin - Check the condition of the peristomal and parastomal skin

Effluent Faeces or urine

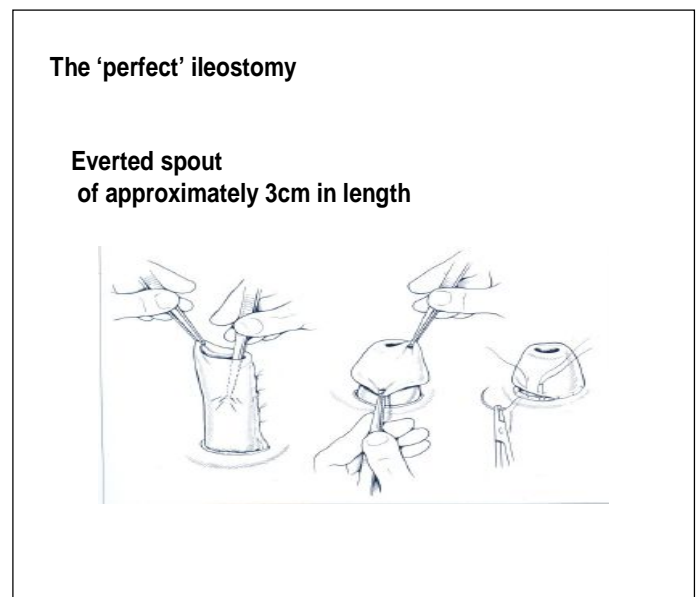
Healthy stomas are

Pinkish red in colour / Always moist and may bleed easily

The ideal colostomy should be a healthy pout of approx 1 cm
i.e.: mobilise to 2cm and evert to 1 cm



The ideal ileostomy should be a healthy spout of approx. 3cm
i.e.: mobilise to 6cm and evert to 3cm.



Each stoma has unique characteristics. Recognising these differences guides the stomatherapist in her choice of suitable ostomy appliances that will keep the patient continent and protect the surrounding skin

IT IS IMPORTANT TO ASSESS THE FOLLOWING

Output / effluent of the stoma
[urine or stool]
Stool consistency [formed or fluid]
Condition of skin [steroids, chemo]
Diameter of the stoma
Financial consideration
Ostomate's ability to manage
Availability of the product

STOMA COMPLICATIONS

Dermatological

Faecal contamination
Adhesive pouch /tape allergy
Mechanical
Bacterial /fungal

Surgical

Parastomal Hernia
Stenosis: cutaneous or deep fascial
Retraction
Prolapse
Peristomal granulation
Bolus Obstruction
Stoma separation
Ischemia



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