AS MANY AS 800,000 people in the United States have stomas.1 This article focuses on colostomy types and immediate postoperative concerns. A future article will focus on pouching systems, skin care, and dealing with complications.

Who needs an ostomy?
Disease, injury, or a congenital defect can alter or impair gastrointestinal (GI) function. If medical management can’t resolve the alteration or restore function—as may be the case in cancer, inflammatory bowel disease, or trauma—the patient may need surgery to bypass or remove the injured or diseased bowel. This may lead to the creation of a temporary or permanent fecal diversion known as a colostomy, where a portion of the colon is pulled through an incision in the abdominal wall. The patient eliminates stool through the surgically created stoma.

The American Society of Colon and Rectal Surgeons and the Wound Ostomy Continence Nurse Society recommend that a certified ostomy nurse be consulted before surgery. The nurse will assess the patient’s abdomen while the patient is standing, sitting, and lying down, and mark the recommended stoma site. This type of evaluation and determination of the optimal stoma site can help reduce postoperative problems such as leakage, the need for custom pouches, skin irritation, pain, and concerns about clothing. The patient and family also can begin learning about ostomy care in a more relaxed atmosphere before surgery.2

Several types of ostomies can be created (see Reviewing ostomy types). You’ll need to know which type the patient will have so you can anticipate what type of drainage to expect and when.
• An ascending colostomy is located in the ascending colon. Stool will typically be semiliquid and contain digestive enzymes that can irritate the skin.
• A transverse colostomy is located in the transverse colon and produces a semiformed stool with fewer digestive enzymes.
• A descending colostomy is located in the descending colon. Stool is semiformed to formed because most of the water has been reabsorbed by this point.
• A sigmoid colostomy is located in the sigmoid colon. The stool is formed.
• If the entire colon needs to be removed or bypassed, an ileostomy is constructed from a portion of the small intestine. Because this stoma is created high in the GI tract, the stool is generally high-volume and liquid.3
• In cases where the bladder needs to be removed or bypassed, a urostomy or ileal conduit is created by implanting the ureters into a small segment of the ileum and bringing this segment to the abdominal wall as a stoma.

Stoma location depends on many factors, including the disease process or injury, the patient’s health, presence of comorbid conditions, and short- and long-term goals.

Psychosocial issues
Before considering the physical aspects of ostomy management, talk to patients about their feelings, concerns, and fears. A patient who’s battled inflammatory bowel disease for many years, for example, may view an ostomy as a way to relieve symptoms and achieve a normal lifestyle. Other patients may find the ostomy an unexpected and devastating experience. Provide emotional support and refer patients for professional help if needed.

Postoperative concerns
In the immediate postoperative period, the stoma should be edematous, dark pink to red, and moist. A pale stoma may indicate anemia, and a dark or purple-blue stoma may indicate ischemia.

The stoma may be round, oval, or somewhat irregular. Most changes in size and shape occur over the first 6 to 8 weeks, so you may need to adjust the ostomy pouching system frequently during this time.4

The degree to which a stoma protrudes from the abdominal wall will help to determine the most appropriate type of pouching system. A moderately protruding stoma (1 to 3 cm) with the opening in the center is considered ideal, as the stool easily flows into the pouching system.

Maintaining a seal can be challenging when the stoma is level with the skin or retracted (beneath skin level). On the other hand, a long stoma may be psychologically offensive to the patient and may be difficult to disguise under clothing. A long stoma also is vulnerable to traumatic injury, laceration, or damage from being folded or bent over into the pouching system.3
Because patients with ostomies have no voluntary control over the elimination of stool and gas, educate them about the effects food may have on bowel patterns. For example, beer, carbonated beverages, and dairy products are likely to produce gas. Eggs, cheese, and fish produce odor. Encourage them to consume a well-balanced diet as recommended by their healthcare provider.

Postoperative stoma edema may persist for up to 6 weeks. Because of this, the intestinal diameter may be narrowed and high-fiber foods (such as apple skins, nuts, and raisins) may have difficulty passing through.

Certain medications or dietary supplements may change stool color, odor, or consistency. Also, drug absorption can vary significantly, depending on stoma location. In patients with an ileostomy or transverse colostomy, drugs that are timed-release, sustained-release, or enteric-coated may not be completely absorbed. Make sure a healthcare provider and pharmacist review every patient’s medication list initially and when the regimen is changed.

REFERENCES

Diane Deitz is an advanced practice nurse in wound and ostomy management at Jersey Shore University Medical Center in Neptune, N.J. Judy Gates is an independent consultant in wound and ostomy home health and long-term care in Peoria, Ariz.