Most patients who have a stoma experience complications at some point. Nurses need to provide prompt assessment, advice and referral for specialist help if required.

Management of stoma complications

In this article...
- An overview of the most common problems with stomas
- How to assess patients who develop complications
- Managing the most common problems in stoma care

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Abstract

More than 100,000 people in the UK have a stoma and most experience problems at some point. This article gives an overview of some of the more common complications and possible solutions. Treatment often involves using stoma accessories, which are products used in conjunction with stoma appliances. Nurses or patients can also contact the stoma specialist nurse in their local hospital for further help and advice.

Nearly three-quarters (73%) of people with a stoma experience skin problems, and over two-thirds try to resolve these without nurse involvement (Smith et al, 2002). It is vital that nurses provide prompt assessment and help when patients who have complications do not seek help.

Stoma appliances are used to collect and contain the stomal output of either faeces and flatus or urine. Closed appliances are most commonly used for colostomies, drainable ones for ileostomies, and drainables one with a tap for urostomies (Fig 1a-c).

Sometimes, problems occur that require nursing intervention. This article explores some of the more common problems: sore skin; appliance leakage; stoma retraction; prolapsed stoma; parastomal hernia; food bolus blockage; and urinary infection. Treatment might take the form of patient advice or provision of stoma accessories that can be used with the stoma appliance to resolve problems.

Assessment
Nurses should carry out a thorough assessment of the problem before starting any treatment (Black, 2011). This should include assessing symptoms and observing the stoma and the peristomal (surrounding) skin. They should also review how long the problem has existed and any previous treatments. If problems do not resolve quickly or further advice is needed, practitioners should contact a stoma specialist nurse.

Sore skin
Sore peristomal skin is one of the most common problems reported by people with a stoma. Symptoms can include red but intact skin (erythema). As problems worsen, the skin can become broken, oozing, eroded or ulcerated. The cause of the soreness needs to be investigated before treatment is started. A common cause is the stomal output coming into contact with the peristomal skin (Nybaek and Jemec, 2010).

Sore skin can occur as a result of the aperture in the stoma flange being the wrong size. If it is too small, the flange tries to stick onto the “wet” stoma, which leads to a leaking appliance; if it is too large, faeces or urine can rest on the abdominal skin, causing the skin to break down (Cronin, 2008a). These problems can be resolved by remeasuring the stoma and re-educating the patient on creating an appropriately sized aperture.

Skin can also become broken due to frequent appliance removal, which is called skin stripping. For example, if a colostomy produces loose stool, a drainable bag may be more appropriate to minimise the number of times the flange is removed from the skin. It is essential to assess the cause of any new symptoms, such as an infection.

For a patient with a colostomy who has frequent bowel motions, a two-piece closed appliance might be more suitable (Cronin, 2008b). Two-piece appliances come in two sections: one is adhesive and is known as the flange, base plate, face plate or wafer and can be left in situ for several days; the other part – the “bag” – can be replaced when needed (Fig 1b).

When the skin is erythematous but intact, a skin protection barrier might be useful. These are available in the form of sprays or wipes and are used directly on cleaned and dried skin before the appliance is put in place. A stoma barrier cream can be used sparingly if the skin needs protection and is dry. If the skin is broken and wet, a protective stoma powder might be useful to dry and protect it.

Powder should be used on the peristomal skin after it has been cleaned and dried. It is important to clean the broken skin – even though this is unpleasant for the patient – and to try to dry it. When powder is added to wet areas of skin, any excess should be removed (particularly from intact skin), as it will impair the adhesion of the new stoma flange (Williams, 2006). Some patients report an uncomfortable feeling for a short period after powder has been applied.

Difficulty removing the appliance
If assessment shows that rough removal of the appliance is making the skin sore, the

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The patient must be re-educated to be gentler. Such problems can include “picking” in one area to remove the appliance, resulting in ulceration of that area.

Some people have difficulty in removing the stoma appliance, which can result in them pulling it too hard, causing skin stripping. This can be resolved by teaching them to remove the appliance gently or by using an adhesive remover spray or wipe (Rudoni, 2008).

If a residue is left on the skin that collects fluff from the patient’s clothes, an adhesive remover might be useful. Soap can be used but it can dry the skin so it is generally advisable to avoid using it on peristomal skin.

Appliance leaks
Williams et al (2010) found that the majority (85%) of people with a stoma had experienced appliance leakage. Stoma appliances can leak for a number of reasons, such as being overfull. If this is the case, patients need to be re-educated to remove or empty their appliance when necessary.

Extremely liquid stool can leak under the flange (the adhesive part of the appliance); this should be investigated if the symptom is new. If the output is consistently loose, it might be useful to try medication to thicken it, such as loperamide, or by dietary changes such as reducing the fibre content of food. Thickening agents are available from appliance manufacturers; these are placed into the stoma bag and thicken the contents, making leakage less likely.

If the skin is uneven, a stoma seal, also called a washer or ring, might be necessary to make the flange more secure (Burch, 2008). Seals can provide greater adhesion around a stoma, thereby reducing the risk of leakage. They can be used in small skin dips to level the surface of the skin by breaking the seal into small parts. Adhesive paste might also be useful.

If the outer edges of the flange lift up when the patient moves, a flange extension might be beneficial. If the appliance does not feel securely held to the abdomen, a thin, elastic belt hooked onto the flange might be useful.

Stomal retraction
A retracted stoma is one that is pulled into the abdomen instead of being minimally raised above the level of the skin (for a colostomy) or having no spout (for an ileostomy or urostomy). This kind of stoma can result immediately after surgery if insufficient bowel is mobilised or at a later date, for example if the patient gains weight.

A retracted stoma can lead to faeces

FIG 1. TYPES OF STOMA APPLIANCE

a. One-piece urostomy bag with bung to allow frequent drainage of urine

b. Drainable stoma bag useful for high output stomas

c. Stoma flange for two piece appliances; One piece closed stoma bag
Review

Stomal prolapse
A prolapsed stoma can be described as the stoma becoming longer, sometimes by six inches (15cm) or more. This can cause a number of problems, such as reducing the capacity of the appliance to collect the faeces or urine; in such cases a larger appliance can be used. A prolapse can also cause a dragging sensation or be unsightly.

Sometimes the prolapsed stoma will go back into the body overnight, but it can also be manipulated back into the body (Dukes, 2010).

A stoma shield can be worn to hold the stoma in during the day to prevent prolapse from occurring. In some cases, surgery may be indicated to remove the prolapse but it can recur. A discoloured stoma requires urgent review and may also need surgery.

Parastomal hernia
A parastomal hernia can be described as a swelling of the abdomen around the stoma. This is generally unsightly and can be uncomfortable, but does not always require surgical intervention.

Patients need to be aware to look for signs of stomal discolouration and a lack of bowel motion, which require urgent surgery.

While hernias can often be managed by a support belt, prevention is preferable. Nurses should advise patients to avoid heavy lifting and to undertake tasks gradually, as they feel able, in the first three months after stoma formation. There is some evidence that wearing a support belt and undertaking exercises to strengthen the abdominal wall can reduce the risk of a hernia (Thompson and Trainor, 2007).

Food bolus blockage
People with an ileostomy may experience a blockage caused by poorly chewed and high-fibre foods. Foods that might cause problems include celery, nuts, sweetcorn, fruit and vegetable skins and dried fruit. Signs of a blockage include the ileostomy not working, a distended abdomen and nausea.

If a blockage occurs, patients should be advised to stop eating and to continue to drink until it passes (Black, 2009). If the blockage does not pass, the patient might need to be admitted to hospital for treatment; surgical intervention is, however, rare.

Urinary infection
People with a urostomy may develop a urinary infection, which manifests as cloudy, malodorous urine (Nazarko, 2008). A specimen should be taken by inserting a urinary catheter a short way into the urethra to collect the urine (a sample should not be taken from the appliance). Antibiotics may be necessary.

Conclusion
People with stomas may experience a range of problems, but these can often be resolved with advice from a nurse.

Sometimes specialist stoma accessories might be needed, such as sealls, adhesive paste or belts. If simple advice does not solve the problem, practitioners should contact a stoma specialist nurse.

References

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