SEXUALITY FOLLOWING STOMA FORMATION 2: NURSING CARE

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This is the second of a two-part unit on issues surrounding sexuality following stoma formation. Part 1 outlined background, and the need to provide holistic patient care that incorporates both the physical and psychosocial issues surrounding stoma formation. This part outlines practical advice and support that nurses can provide for patients.

Sexuality following stoma formation can be compromised, both physically and psychosocially, in all age groups and in both sexes. Body image plays a huge role in patients’ psychological health following stoma formation and can greatly inhibit sexual desire and ability (Black, 2000; Salter, 1996). Believing themselves to be less attractive and having concerns about the safety of the stoma during sexual activity are two of the more common patient anxieties (Salter, 1996). It is imperative that healthcare professionals discuss these concerns with patients pre- and post-operatively to minimise the risk of alteration to sexuality.

SEXUAL FUNCTION
The development of a new orifice can lead to sexual connotations for stoma patients and their partners. McVey et al (2001) reported that men can view a stoma as a feminine object, representing an opening comparable to a vagina that may bleed when cleaned, in a similar way to menstruation. Similarly, women may liken a protruding stoma to a penis (Salter, 1996).

Price (1990) also stated that people expect elimination to occur out of sight, so the presence of a bag filled with faeces or urine on an area of skin usually considered clean and intact can be distressing for both patients and partners.

LEARNING OBJECTIVES
1. Explain the potential alterations to sexuality following stoma formation.
2. Identify how disturbance to sexuality following this surgery can be minimised.

Advice such as rolling the bag up and taping it down so it does not move, emptying it before sexual activity or using a smaller bag or a stoma plug should be discussed with couples to alleviate anxiety and give reassurance that a stoma should not affect a loving relationship (Porrett, 2005).

There are stoma covers and special underwear available that may improve body confidence (Colostomy Association, 2007). A simple piece of clothing or a cover may make a vast difference to a person’s sexual well-being and may be the difference between feeling comfortable sexually and not engaging in sexual activity (Manderson, 2005).

Sexual function in men
Damage to the autonomic nerve supply or muscle caused by the trauma of pelvic surgery can lead to erectile or ejaculation problems or irreversible impotence. Consequently, couples may need to explore alternative ways of sharing a loving relationship.

Erectile problems are fairly common among men who have rectal surgery (Persson and Hellstrom, 2002). However, Kelly (2001) argued that impotence is often likely to be psychological in origin. Symms et al (2008) found that the presence of a stoma in male veterans was generally correlated with reduced sexual activity and increased erectile dysfunction. Causes can be reversed or reduced with medication, counselling and implants (Kelly, 2001).

Impotence can cause additional psychological problems in men as they may consider themselves inadequate as a lover, less manly and physically weak. Apprehension about achieving and maintaining an erection can exacerbate that very problem.

Other risk factors for erectile dysfunction include smoking, diabetes, hypertension and hyperlipidaemia, so advice on risk modification should be given. This may include input from other members of the multidisciplinary team, such as dietitians and specialist diabetes nurses.

It is often not known for many months after surgery whether a man’s sexual function has been affected by the procedure, since psychological problems can also inhibit the ability to achieve or maintain an erection (White, 1997). Therefore, any issues require follow-up post discharge. Men may feel more comfortable speaking to another man about such matters, so provision should be made if necessary.

It must be remembered that informed consent for any procedure can only be gained when patients have all the necessary information, and this includes any potential side-effects regarding sexuality.

Sexual function in women
Women may experience vaginal tenderness, dryness, discharge or pain following stoma formation, especially if the rectum is removed. Again, these symptoms can be exacerbated by anxiety and stress. It is important that patients are aware of these possible consequences and reassured that such problems can be rectified with lubricants, analgesia or using a different position for intercourse (Galt and Hill, 2002; Salter, 1996).

POSITIONING THE STOMA
Positioning of the stoma is important to ensure patients’ lives are as comfortable as possible following surgery. It is essential for post-operative recovery to ensure optimum quality of life, since incorrectly sited stomas can lead to leakage, management issues...
and ultimately physical and psychosocial problems (Rutledge et al, 2003). This can have a negative impact on sexual health as patients may become concerned about the stoma leaking or being in the way during sexual activity.

A stoma nurse often undertakes the positioning, taking into consideration clothing style, lifestyle, dexterity and ability to see the stoma, and suitability of the stoma lying, sitting and standing (White, 1997). They should also not be positioned over existing scars, in folds of skin or near to the umbilicus (McGrath and Black, 2005). Careful positioning helps to minimise the risk of leakage and irritation of previously damaged skin, and ensures the stoma is comfortable.

Patients often worry that a stoma will lead to major lifestyle changes, especially in relation to stopping hobbies. These concerns may be allayed with advice about specialist clothing such as swimming costumes, and reassurance that physical activity can continue as normal without risk to the stoma.

**PAIN MANAGEMENT**

If the rectum is to be removed during surgery, phantom rectal pain should be discussed pre- and post-operatively, as this can adversely affect sexuality and quality of life (Colostomy Association, 2003). Phantom rectal pain occurs because the nerve supply to the rectum may still be intact, although the rectum has been removed.

Any post-operative pain can affect body image, and physical health can be affected through increases in stress. Pain can affect sexuality through worries about sexual intercourse causing discomfort, and can have a direct effect on libido and general mood (Persson and Hellstrom, 2002).

In addition, strong analgesics used to treat such pain can induce impotence and vaginal dryness, cause fatigue and lower libido.

Pain itself is often worse than the effects of treatment and should be dealt with promptly, if not pre-emptively (Marek and Boehnlein, 2007). Medication such as gabapentin can reduce neuropathic pain and should be considered (British Medical Association and Royal Pharmaceutical Society of Great Britain, 2006).

**HOLOISTIC ASSESSMENT**

Clearly, the assessment and management of patients undergoing stoma formation is complex, and requires skilled practitioners who understand patients’ physiological and psychosocial needs. Patients are often required to come to terms with the realisation of surgery and changes in body image and lifestyle in a short space of time. Any patient undergoing surgery is likely to have physical and psychosocial concerns.

Sexuality may be adversely affected at the time of discharge, through concerns about ability to cope at home and diminishing physical and psychological sexual function.

Although the procedure may appear routine to staff, surgery is a unique experience for each person that can cause anxiety and stress. There is a lack of recent research on sexuality in stoma patients (Hendren et al, 2005; McVey et al, 2001; White, 1997). Therefore care must be based on the best available evidence, in addition to professional expertise from stoma nurses and surgeons. Roper et al (2002) argued that sexuality cannot be isolated from the rest of the patient assessment and should be considered as an integral part of any assessment.

**ENSURING HIGH-QUALITY CARE**

Despite research showing that collaboration between practitioners is the most effective way of providing high-quality care (McGrath, cited in Leathard, 2003), this does not always occur. Lack of staff collaboration can reduce patient well-being (Tierney, 1996).

Stoma nurses often have the most input, but there should also be involvement from the surgeon and other members of the team. Nurses on the wards are in the best position to ensure needs around sexuality issues are met. Roper et al (2002) argued that sexuality is not just a consideration outside the hospital setting, since merely being in hospital, in mixed bays and with strangers, tends to damage body image.

Sexuality is a major aspect of personality and individual behaviour throughout life and should be discussed unreservedly, as with every other aspect of care. It should form part of the surgeon’s consultation and not be considered purely a nursing issue.

The use of assessment tools prompts professionals to cover all aspects of each area of patient care (Roper et al, 2002), so a specific tool relating to sexuality may prove useful. Campbell (2007) also referred to the need for social support for patients with a cancer diagnosis and their families to reduce stress and improve quality of life.

Further research in this complex area is needed to inform policies and best practice guidelines, to ensure evidence-based care and give patients the best possible chance of maintaining sexual relationships and realistic body images. ■

**KEY REFERENCES**


- The full reference list for this unit is available in Portfolio Pages at nursingtimes.net.

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