Colostomy Guide

Colostomy surgery is done for many different diseases and problems. Some colostomies are done because of cancer; others are not. For instance, a child may need one because of a birth defect. Depending on the reason or type of problem, a colostomy may be needed for a short time (temporary) or it may be needed for the rest of a person's life (permanent).

For the thousands of people who have serious digestive diseases, a colostomy can be the start of a new and healthier life. If you've had a chronic problem or a life-threatening disease like colorectal cancer, you can look forward to feeling better after you recover from your operation. You can also look forward to returning to the activities you enjoyed in the past.

What Is a Colostomy?

(large intestine) is brought through this opening in the skin to form a *stoma*.

A colostomy might only be needed for a short time (temporary), maybe for 3 to 6 months. A temporary colostomy may be used when a part of the colon needs time to rest and heal from a problem or disease. But sometimes a disease, such as cancer, is more serious and a colostomy may be needed for the rest of a person's life (permanent).

- What does a colostomy do?

Where the colostomy stoma will be on the abdomen depends on which part of the colon is affected. Some colostomies are large, some small; some are on the left side of the abdomen, some are on the right, others may be in the middle. A Wound Ostomy Continence nurse (WOCN or WOC nurse) or the surgeon will figure out the best location for your stoma. (A WOC nurse is a specially-trained registered nurse who takes care of and teaches ostomy patients. This nurse may also be called an ostomy nurse.)

When you look at a stoma, you are actually looking at the lining (the *mucosa*) of the intestine, which looks a lot like the inside lining of your cheek. The stoma will look pink to red. It’s warm and moist and secretes small amounts of mucus.

The way the stoma looks depends on the type of colostomy the surgeon makes and on individual body differences. It may look quite large at first, but will shrink to its final size about 6 to 8 weeks after surgery. The shape will be round to oval. Some stomas may stick out a little, while others are flat against the skin.

Unlike the anus, the stoma has no valve or shut-off muscle. This means you won’t be able to control stool passing from the stoma, but sometimes bowel movements can be managed in other ways. There are no nerve endings in the stoma, so the stoma itself is not a source of pain or discomfort.

Since nutrients are absorbed in the small intestine, a colostomy does not change how the body uses food. The main functions of the colon are to absorb water, move the stool toward the anus, and then store stool in the rectum until it's passed out of the body. When a colostomy changes the stool's route, the storage area is no longer available.

The higher up in the colon the colostomy is made, the shorter the colon is. A shorter colon means it has less time to absorb water, making the stool softer or more liquid. A colostomy further down in the colon, near the rectum, will put out stool that has been in the intestine a longer time. Depending on the effects of illness, medicines, or other forms of treatment, the longer colon can put out a more solid or formed stool. Some people with colostomies find that they are able to pass this stool at certain times of the day with or without the help of irrigation. (See Caring for a Colostomy.)

United Ostomy Association of America (UOAA). *New ostomy patient guide: Colostomy, ileostomy, urostomy, continent diversion.* Accessed at https://www.ostomy.org/wp-content/uploads/2018/05/All-In-One-New-Patient-Guide_2018.pdf on October 2, 2019.

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Types of Colostomies and Pouching Systems

A colostomy can be short-term (temporary) or life-long (permanent) and can be made in any part of the colon. The different types of colostomies are based on where they are located on the colon.

- Temporary colostomies
- Permanent colostomies
- Transverse colostomies
- Bowel movements with a transverse colostomy
- Ascending colostomy
- Descending and sigmoid colostomies

Permanent colostomies

When part of the colon or the rectum becomes diseased, a long-term (permanent) colostomy must be made. The diseased part of the bowel is removed or permanently rested. In this case, the colostomy is considered permanent and is not expected to be closed in the future.

Transverse colostomies

A transverse colostomy is one of the most common types. There are 2 types of transverse colostomies: the loop transverse colostomy and the double-barrel transverse colostomy. The transverse colostomy is in the upper abdomen, either in the middle or toward the right side of the body. This type of colostomy allows the stool to leave the body before it reaches the descending colon. Some of the colon problems that can lead to a transverse colostomy include:

- Diverticulitis. This is inflammation of diverticula (little sacs along the colon). It can cause abscesses, scarring with stricture (abnormal narrowing), or rupture of the colon and infection in severe cases.
- Inflammatory bowel disease
- Cancer
- Obstruction (blockage)
- Injury
- Birth defects

If there are problems in the lower bowel, the affected part of the bowel might need time to rest and heal. A transverse colostomy may be used to keep stool out of the area of the colon that’s inflamed, infected, diseased, or newly operated on – this allows healing to take place. This type of colostomy is usually temporary. Depending on the healing process, the colostomy may be needed for a few weeks or months, but possibly for years. If the colon heals over time, the colostomy is likely to be surgically reversed (closed). You will have normal bowel function after it's reversed.

A permanent transverse colostomy is made when the lower portion of the colon must be removed or permanently rested, or if other health problems make the patient unable to have more surgery. The colostomy is then the permanent exit for stool and will not be closed in the future.

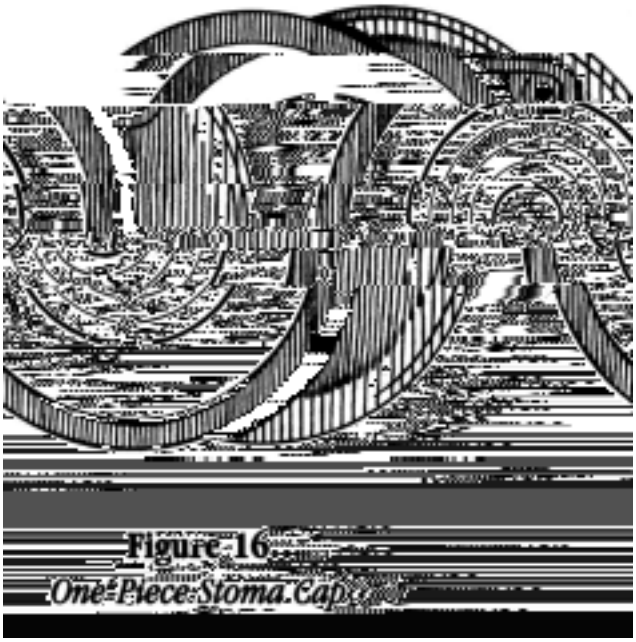
Loop transverse colostomy (Figures 2 and 3): The loop colostomy may look like one very large stoma, but it has 2 openings. One opening puts out stool, the other only puts

The opening of the skin barrier or wafer of the pouch needs to fit your stoma. The opening should be no more than 1/8 inch larger than the stoma. Depending on the pouch design, you may need to cut a hole out for your stoma, or the wafer may be sized and pre-cut. The size of the hole is important because the wafer is designed to protect the nearby skin from the stoma output and be as gentle to the skin as possible.

Keep in mind a stoma's size can change if it becomes swollen or for other reasons. For example, after surgery, your stoma may be swollen for about 6 to 8 weeks. During this time the stoma should be measured about once a week. A measuring card may be included in boxes of pouches, or you can make your own template to match your stoma shape and get the best fit.

Stoma cap

If your colostomy puts out stool at regular, expected times, you may be able to use a stoma cover instead of always wearing a pouch. You can place neatly-folded gauze or tissue, dabbed with a small amount of water-soluble lubricant over the stoma, and cover it with a piece of plastic wrap. This can be held in m /F10with medical tape, underclothes, or an elastic garment. Plastic, ready-made stoma caps (Figure 16) are also available.



Hyperlinks

1. www.cancer.org/cancer/managing-cancer/treatment-types/surgery/ostomies/ileostomy.html

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Caring for a Colostomy

Use the right size pouch and skin barrier opening. An opening that’s too small can cut or injure the stoma and may cause it to swell. If the opening is too large, output could get to and irritate the skin. In both cases, change the pouch or skin barrier and replace it with one that fits well.

Change the pouching system regularly to avoid leaks and skin irritation. It's important to have a regular schedule for changing your pouch. Don't wait for leaks or other signs of problems, such as itching and burning.

Be careful when pulling the pouching system away from the skin and don't remove it more than once a day unless there’s a problem. Remove the skin barrier gently by pushing your skin away from the sticky barrier rather than pulling the barrier away from the skin.

Clean the skin around the stoma with water. Dry the skin completely before putting on the skin barrier or pouch.

Watch for sensitivities and allergies to the adhesive, skin barrier, paste, tape, or pouch material. They can develop after weeks, months, or even years of using a product because you can become sensitized over time. If your skin is irritated only where the plastic pouch touches it, you might try a pouch cover or a different brand of pouch. A stoma nurse can offer ideas if needed. Pouch covers are available from supply manufacturers, or you can make your own. You may have to test different products to see how your skin reacts to them.

Colostomy irrigation (for descending and sigmoid colostomies only)

Colostomy irrigation is something that can be done with certain types of colostomies to help move stool through the colon. If you have a descending or sigmoid colostomy, you may choose to manage your colostomy with irrigation. Irrigation is simply putting water into the colon through the stoma to help regulate bowel movements.

Colostomy irrigation has been used for many years, but it's not used as much now as years ago. This is probably because pouch systems have improved.

Whether to irrigate is up to each person, but you should fully discuss it with your doctor or ostomy nurse before a decision is made. Your doctor or ostomy nurse will teach you how to irrigate your colostomy. The procedure may be a little different from what we describe here, depending on the experience of the person teaching you.

Talk to your doctor or ostomy nurse about irrigation. Whether you will choose to irrigate your colostomy and how you do it depends on many factors, such as your:

- Lifelong bowel habits
- Activity level
  Skill and comfort level with irrigation

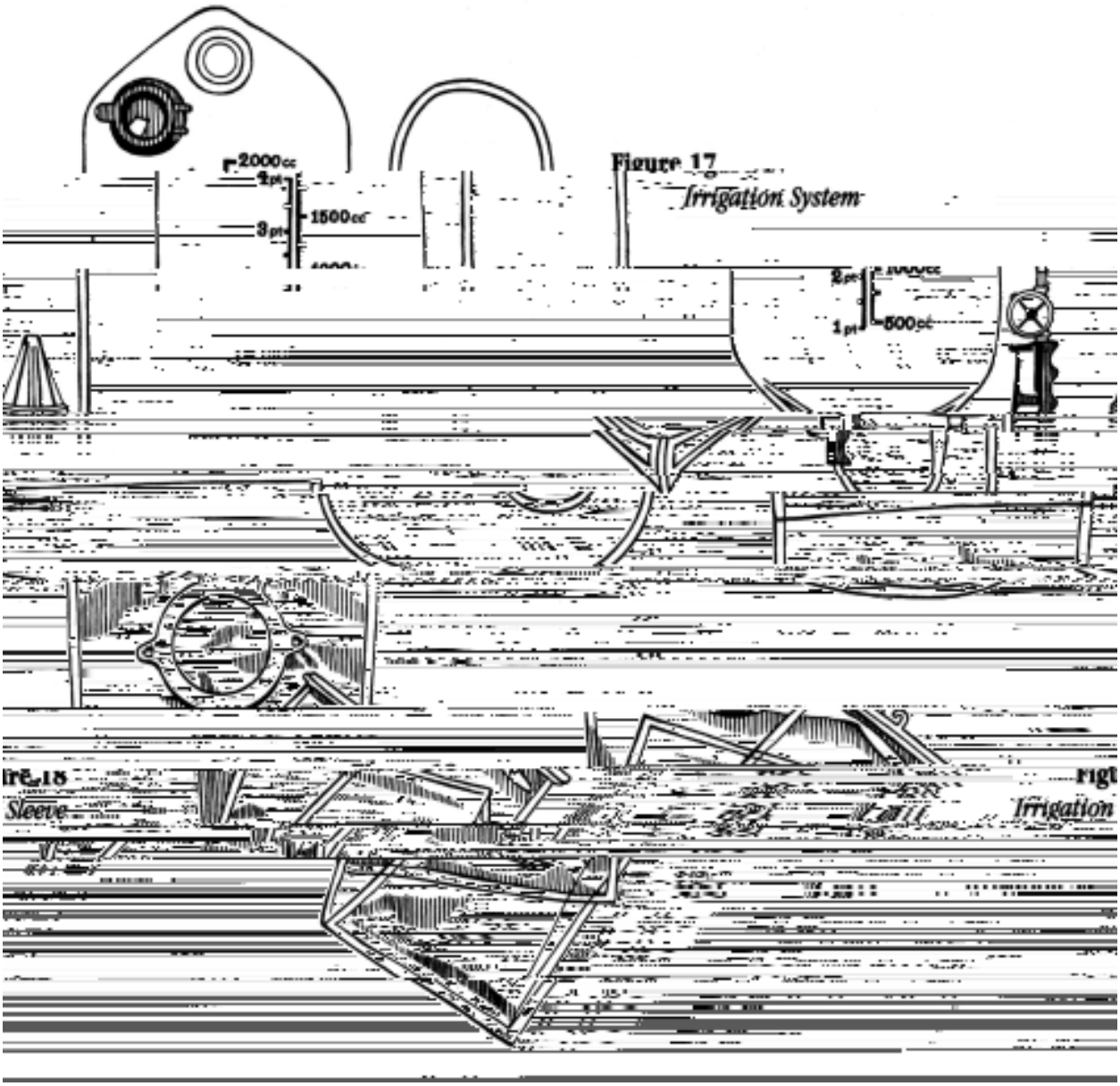
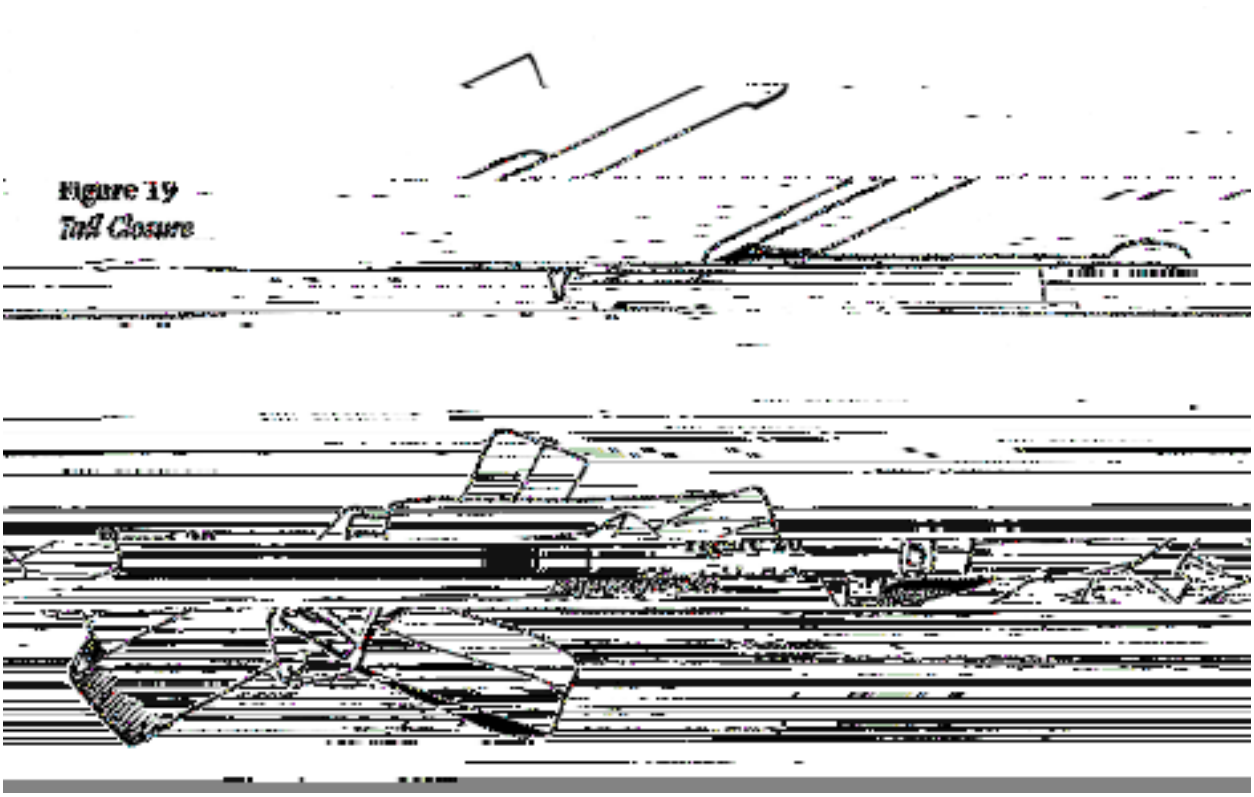


Figure 17
Irrigation System



If you choose to irrigate

When to irrigate

- Choose a time in the day when you know you'll have the bathroom to yourself.
- Irrigation may work better if it's done after a meal or a hot or warm drink. Also, consider irrigating at about the same time of day you usually moved your bowels before you had the colostomy.

How to irrigate

- Get your irrigation supplies together
- Clamp the tubing and put 1000 cc (about 1 quart) of lukewarm (not hot) water in the irrigating container. You may need a little less. NEVER connect the tube directly to the faucet.
- Hang the container at a height that makes the bottom of it level with your shoulder when you are seated.
- Sit on the toilet or on a chair next to it. Sit up straight.

- Seal the plastic irrigation sleeve onto your skin barrier and put the bottom end of the sleeve in the toilet bowl.
- Wet the end of the cone or lubricate it with water-soluble lubricant.
- Remove air bubbles from the tubing by opening the clamp on the tubing and letting a small amount of water run into the sleeve.
- Re-clamp the tubing and put the cone into your stoma as far as it will go, but not beyond its widest point.
- Slowly open the clamp on the tubing and allow the water to gently flow into your bowel. The water must go in slowly. You may shut the clamp or squeeze the tube to slow or stop the water flow. It takes about 5 minutes to drip in 1000 cc (about 1 quart) of water.
- Hold the cone in place for about 10 seconds after all the water has gone in.
- The amount of water you need depends on your own body. You may need less, but do not use more than 1000 cc (1 quart). The purpose of irrigating is to remove stool, not to be strict about the amount of water used.
- You should not have cramps or nausea while the water flows in. These are signs that either the water is running in too fast, you're using too much water, or the water is too cold. After the water has been put in, a bowel movement-type cramp may happen as the stool comes out.
- After the water has run in, remove the cone. Output or "returns" will come in spurts over the next 45 minutes or so.
- As soon as most of the stool has come out, you may clip the bottom of the irrigating sleeve to the top with a tail closure clip. This allows you to move around, bathe, or do anything you wish to pass the time.
- When done, recheck the wafer seal and put your usual pouch back on. Rinse the bag, cone, and sleeve and hang to dry.

With time and experience, you'll know when all the water and stool have come out. A squirt of gas may be a sign that the process is done, or the stoma may look quiet or inactive. If the complete irrigation process always takes much more than an hour, talk to your doctor or ostomy nurse.

Emptying and changing the pouching system

You'll be taught how to change and empty your pouching system before you leave the hospital. You don't have to use sterile supplies. For instance, facial tissue, toilet paper, or paper towels can be used to clean around the stoma instead of sterile gauze pads.

How to empty the pouch

Empty the ostomy pouch when it is about 1/3 to 1/2 full to keep it from bulging and leaking. Follow these steps:

- Sit as far back on the toilet as you can or on a chair facing the toilet.
- Place a small strip of toilet paper in the toilet to decrease splashing.
- Hold the bottom of the pouch up and open the clip on the end or tail of the pouch.
- Slowly unroll the tail over the toilet.
- Gently empty the contents. You can put some toilet paper in the toilet first to help avoid splashing if needed.
- Clean the outside and inside of the pouch tail with toilet paper.
- Roll up the end of the pouch and clip.

When to change the pouching system

It's best to have a regular changing schedule so problems don't develop. Different pouching systems are made to last different lengths of time. Some are changed every day, some every 3 days or so, and some just once a week. It depends on the type of pouch you use.

There may be less bowel activity at certain times in the day. It’s easiest to change the pouching system during these times. You may find that early morning before you eat or drink is best. Or allow at least 1 hour after a meal, when digestive movement has slowed down. Right after surgery, ostomy output may be thin and watery. As the output gets thicker, you’ll be better able to find the best time for changing your system.

Factors that affect the pouching system seal

The pouching system must stick to your skin. It’s important to change it before it loosens or leaks. The length of time a pouch will stay sealed to the skin depends on many things, such as the weather, skin condition, scars, weight changes, diet, activity, body shape near the stoma, and the nature of the ostomy output. Here are some other things that may affect how long a pouch sticks:

- Sweating will shorten the number of days you can wear the pouching system. Body heat, added to outside temperature, will cause skin barriers to loosen more quickly than usual.
- Moist, oily skin may reduce wearing time.

- Weight changes will affect how long you can wear a pouch. Weight gained or lost after ostomy surgery can change the shape of your abdomen. You may need an entirely different system.

You will not need special clothes for everyday wear. Ostomy pouches, especially certain kinds, are fairly flat and hard to see under most clothing. The pressure of elastic undergarments won't harm the stoma or prevent bowel function.

If you were sick before surgery, you may find you can now eat normally for the first time in years. As your appetite returns, you may gain weight. This can affect the clothes you choose more than the pouching system itself.

Snug undergarments such as cotton stretch underpants, t-shirts, or camisoles may give you extra support, security, and help conceal pouches. A simple pouch cover adds comfort by absorbing body sweat and keeps the plastic pouch from resting against your skin. Men can wear either boxer or jockey-type shorts.

Managing colostomy problems

Gas (flatulence)

Right after surgery it may seem that you have a lot of gas almost all the time. Most abdominal surgery is followed by this uncomfortable, embarrassing, yet harmless symptom. Gassy noises or stomach rumblings may be a concern. If you are concerned about others nearby hearing this, you can say, "Excuse me, my stomach's growling." If you feel as though you are about to release gas when you're with people, casually fold your arms across your belly so that your forearm rests over your stoma. This will muffle most sounds. Check with your ostomy nurse about products you can take to help lessen gas. Certain foods may cause gas, such as eggs, cabbage, broccoli, onions, fish, beans, milk, cheese, carbonated drinks, and alcohol.

- Eating regularly will help prevent gas.
- Eat smaller amounts of food 4 to 5 times a day.
- **DO NOT** skip meals to avoid gas or output.

Odor

Many factors, such as foods, normal bacteria in your intestine, illness, certain medicines, and vitamins can cause odor.

- Some foods can produce odor: eggs, cabbage, cheese, cucumber, onion, garlic, fish, dairy foods, and coffee are among them. If you find that certain foods bother you, avoid them.

- Use an odor-resistant pouch.
- Check to see that the skin barrier is stuck securely to your skin.
- Empty the pouch often.
- Place special deodorant liquids and/or tablets in the pouch.
- There are some medicines you can take that may help. Check with your doctor or ostomy nurse about these products and how to use them. Some things that many people have found help with odor are chlorophyll tablets, bismuth subgallate, and bismuth subcarbonate. Keeping air deodorizers in that room can also control odor very well when you are emptying the pouch

Finding medicine capsules in your pouch

Be aware that coated tablets or time-released capsules may come out whole in the pouch. In most cases, this means you didn't get the medicine. If you notice this, talk with your health care provider or pharmacist. There may be other medicines you can use to make sure you're getting what you need. Liquid or liquid gel medicines tend to absorb faster and may work better for you.

Severe skin problems

Large areas of skin that are red, sore, and weeping (always wet) will keep you from getting a good seal around your stoma. It's important to treat minor irritations right away. If you have a large irritated area, or one that's getting larger despite special care, contact your doctor or ostomy nurse. They may prescribe medicine to take by mouth or to put around your ostomy to help dry out and heal your skin.

For deep pressure ulcers caused by a very tight ostomy belt, loosen or remove the belt and call your doctor or ostomy nurse right away. You will need treatment.

Blockage (obstruction)

There will be times when your ostomy does not have output for short periods of time. This is normal. But, if your stoma is not active for 4 to 6 hours and you have cramps, pain, and/or nausea, the intestine could be blocked (the medical word is *obstructed*). Call your doctor or ostomy nurse right away if this happens.

These are some things you can do to help move things through your ostomy:

- Watch for swelling of the stoma and adjust the opening of the wafer as needed until

medicines you might be taking. You may be given medicine to help slow things down. Remember, no matter what, you need a well-balanced diet and good fluid intake to have a good output.

Electrolyte imbalance

Electrolytes are salts and minerals in the blood, like potassium, magnesium, and sodium. Keeping them balanced is important. When the colon (large intestine) is removed, you're at a greater risk for electrolyte imbalance. Diarrhea, vomiting, and a lot of sweating can increase this risk.

Dehydration is also a serious concern. Symptoms include increased thirst, dry mouth, decreased urine output, feeling light-headed, and feeling tired. If you get dehydrated, you'll need to drink more fluids. To avoid dehydration, you should try to drink 8 to 10 eight-ounce glasses of fluid a day. If you have diarrhea, you may need more. Drinks such as Gatorade®, PowerAde®, or Pedialyte® contain potassium and sodium. But any liquid containing water (soda, milk, juice, tea, etc.) helps to meet your daily need for fluid.

Loss of appetite, drowsiness, and leg cramps may be signs of sodium loss. Fatigue, muscle weakness, and shortness of breath may be signs of potassium loss. Dehydration, low sodium, and low potassium can all be dangerous and should be treated right away. Keep in mind that some of these symptoms can be caused by other problems which may be emergencies. Call your doctor or 911 right away if you are dizzy, weak, or having other serious symptoms.

Phantom rectum

Phantom rectum is much like the "phantom limb" of amputees who feel as if their removed limb is still there. It's normal for you to have the urge to move your bowels the way you did before surgery. This can happen at any time and may go on for years after surgery. If the rectum has not been removed, you may have this feeling and also may pass mucus when sitting on the toilet. Some people who have had their rectum removed say that the feeling is helped by sitting on the toilet and acting as if a bowel movement is taking place.

Short bowel syndrome

This condition happens when surgery is done to remove a large part of the small intestine. Short bowel syndrome needs special attention because there's not enough intestine left to absorb the nutrients the body needs.

work with the company in question.
- Compare prices when using mail order and the Internet (remember to include shipping costs).
- Keep all your supplies together on a shelf, in a drawer, or in a box in a dry area away from moisture and hot or cold temperatures.
- Order supplies a few weeks before you expect them to run out to allow enough time for delivery. DO NOT stockpile supplies – they can be ruined by moisture and temperature changes.

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