Stomas

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James talks to Dr Oliver Warren about the junior doctor's approach to stomas and the two most common problems - the dusky stoma and high output stomas.

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About Dr Oliver Warren

Oliver Warren is a Colorectal Fellow at the Royal Prince Alfred Hospital, Sydney and an Honorary Lecturer in the Department of Surgery and Cancer at Imperial College London. He gained his Fellowship of the Royal College of Surgeons in 2012 for which he was awarded the Gold Medal for Outstanding Performance. In 2009 he was awarded a doctorate for his thesis investigating the inflammatory response to cardiopulmonary bypass. In 2013 he was awarded the Association of Coloproctology of GB Ireland’s Travelling Fellowship, spending his fellowship at the Cleveland Clinic, USA. To come to Australia he was awarded Imperial College London’s Simpson Smith Travelling Fellowship and the Association of Surgeons in Training’s Travelling Fellowship.

Oliver is the Clinical Director of ‘Prepare to Lead’, a leadership development mentoring scheme for doctors, now based at the King’s Fund, London, which he established in 2007. From 2009 – 2011 he was a member of the NHS National Leadership Council and in 2008 was seconded to the Department of Health where he worked as a clinical advisor to the under-secretary of state. He was a Leadership Fellow at the Health Foundation from 2007 – 2009 and in 2010 was runner-up in the BMJ’s ‘Junior Doctor of the Year’ award.

Stomas

with Dr Oliver Warren (Colorectal Fellow at Royal Prince Alfred Hospital, October 2014), New South Wales, Australia

1. General approach

- Stomas are challenging and are infrequently encountered by the junior doctor
- The only true permanent stomas are for patients who have had their anal sphincter removed (mostly after surgery to remove cancer or surgery for inflammatory bowel disease)
- For all other patients, stomas are temporary (e.g. surgeons trying to rest bowel after a difficult bowel resection)
Colostomy (colon is in continuity with skin), ileostomy (ileum is in continuity with skin)

Ileostomy – tends to be placed in the RLQ abdomen, has a spout, mint sauce/mint jelly/loose porridge consistency (colon has not had chance to remove water)
Colostomy – tend to be placed on the left side of abdomen (or along the lie of the colon), are flat to skin, contents are like normal faeces. The more distal the colostomy, the more faeces-like it is

Case

You’ve been called to see a patient with a stoma that is looking dusky.

2. Approaching the case

- Thorough history and examination
- Why do they have the stoma and how long have they had it for?
- Look at the operation note for the reasons for placement of the stoma and if the surgeon had any concerns.
- Ask the nurses if the stoma’s appearance has changed.
- Examine the stoma
  - Talk to nurses who are experienced with looking after stomas
  - Take the bag off (make sure there’s a bag available to change it)
  - 3 tricks
    - Feel the stoma. It should feel warm. If it feels cold, that’s a concern.
    - Take a 23G or 25G needle and prick the mucosa of the stoma. There should be bright red blood. A dead stoma will have no bleeding or a blackish-purple.
    - Pass a blood tube (with KY Jelly) into the stoma and shine a light through it and look for the mucosa colour. It is not uncommon for the final 1 cm of a stoma to slough off. The rest of the bowel wall or mucosa may be fine. This situation can be managed conservatively.
  - Consider taking a photo and sending it to the surgeon concerned.

A fully dead stoma (black, icy cold, no blood after pricking, black all the way through a blood tube) – a surgical emergency that needs to be in theatre in a few hours. It can’t be left for 24 hours. A dead bowel will make the patient septic, and it is also uncertain how much dead bowel is there.

The stoma has a high output

3. Approaching the case
Far, far more common in ileostomies
Most people have 3 – 4 m of small bowel
The more proximal the stoma sits, the more likely it will be high output
Look at the operation note
Ideal ileostomy output - < 1 L in the first 24 hours
The most common situation is managing the sequelae of a large ileostomy output
Hypokalaemia, hypomagnesemia, hyponatremia are common following large ileostomy outputs and even hypochloremic alkalosis because of loss of acid
When replacing fluids, replace electrolytes (don’t just give normal saline)
If ileostomy doesn't slow down – consider other causes (e.g. intra-abdominal sepsis, check for inflammatory markers and consider a CT abdo/pelvis, send effluent for culture and check for Clostridium difficile/CMV)
Then consider
- Diet – high water intake will increase stoma output and will cause a paradoxical dehydration. Encourage patients to drink electrolyte replacement solutions (e.g. gastrolyte, hydralyte). A Google search can show recipes for home made electrolyte replacement solutions involving salt and sugar.
- Potato chips are excellent for thickening ileostomy output. Marshmallows and jelly babies are also great.
- Avoid high residue/high fibre diets (e.g. raw vegetables, salads, tomatoes, apples)

Antimotility agents
- Loperamide/Imodium/gastrostop – works on opiate receptors to slow the gut down (max dose is 24 mg, but higher doses are used on specialist units)
  - Start on a low dose like 2mg TDS or 2 mg QID
- Codeine can be used but is associated with a higher frequency of side effects
- Fibre supplementation (e.g. Metamucil) but is not as common

Take home messages
Always ask a senior member of a team (e.g. SRMO, registrar, fellow, consultant)
You will regret not asking much more than asking
Stoma therapists, dietitians are all experts
Remember the vast majority of patients with stomas find it very distressing
However, the vast majority do adapt to having a stoma
People with stomas have climbed to the top of Mt Everest, headed up FTSE 500 companies, swum the English channel – it does not stop people from leading a full and active life
Particularly for younger patients, particularly for patients who are not in loving/stable relationships, and particularly for patients of reproductive age. Have this in the back of your mind when you are treating them and caring for them.
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