Stomas

Oct 6, 2014 | 0

colorectal,gastroenterology & hepatology,general surgery,onthepods

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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 the high output stoma.

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, n,

- **For all other patients, stomas are temporary (eg. surgeons trying to rest bowel after a**
- **di ł cult bowel resection)**
- **Colostomy (colon is in continuity with skin), ileoso[f]**

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 Krst 24 hours
- The most common situation is managing the sequelae of a large ileostomy output
- Hypokalemia, hypomagnesemia, hyponatremia are common following large ileostomy outputs and even hypochloremic alkalosis because of loss of acid
- When replacing Kuids, replace electrolytes (don't just give normal saline)
- If ileostomy doesn't slow down – consider other causes (eg. intra-abdominal sepsis,check for inKammatory markers and consider a CT abdo/pelvis, send eOuent for culture and check for Clostridium di ł cile/CMV)
- Then consider
    - Diet – high water intake will increase stoma output and will cause a paradoxical dehydration. Encourage patients to drink electrolyte replacement solutions (eg.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 Kbre diets (eg. 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 eł ects
    - Fibre supplementation (eg. Metamucil) but is not as common

Take Home Messages

- Always ask a senior member of a team (eg. 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 Knd 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.**

- Post-operative drains
- Nutrition
- Gastrostomy feeding tubes