Skin Barrier Selection in an Outpatient Ostomy Clinic

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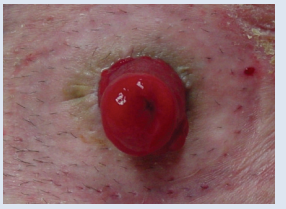
Introduction

The lives of people living with ostomies are significantly influenced by their pouching systems. Ill-fitting skin barriers cause leakage which can contribute to peristomal lesions and trauma to the stoma. Peristomal dermatitis is also often attributed to sensitivity to acrylic adhesive collars of skin barriers.[1] The outpatient ostomy clinic sees patients with new ostomies within 2-weeks for post-op follow-up, as well as patients having problems with long-term existing stomas. The emotional stress associated with leakage and painful skin irritation prompts patients to contact the ostomy clinic for help. Patients often talk about experiences with pouching system leakage. Many times, an improperly cut skin barrier has contributed to the problem. Skin barrier selection for optimal patient outcomes requires consideration of factors such as stoma size and shape, condition of peristomal skin, dexterity, eyesight and patient cognitive status. As patients presented to our clinic, an evaluation of moldable skin barriers* was implemented.

Case Studies

CASE 1

A 30 year old male patient presented to the Outpatient Ostomy Clinic with a rash present to his peristomal skin for 3-4 months. The patient had an original diagnosis of ulcerative colitis in 2000 and underwent subtotal colectomy in 2001. After an extensive history of fistulas and anal stenosis a presumptive diagnosis of Crohn's disease was made. In August of 2009, he underwent an ileal pouch anal anastomosis takedown with an end ileostomy. Patient was using a cut-to-fit skin barrier with an acrylic tape collar. His usual routine included using a spray skin barrier prior to skin barrier wafer application. He reported that the rash began when he ran out of skin barrier spray. He had used Nystatin powder as prescribed by his surgeon. The rash improved, but continued particularly at the proximal lateral edge of the acrylic border. The patient reported that after his appliance changes, the acrylic border would lift up and the skin was very weepy and would crust over. It was suspected that the patient had sensitivity to the acrylic border of the skin barrier. After trialing the moldable skin barrier with the hydrocolloid tape border, the rash resolved. He also trialed a cut-to-fit skin barrier without the tape border. He expressed satisfaction with the moldable product and converted to this pouching system.



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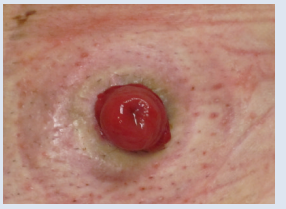

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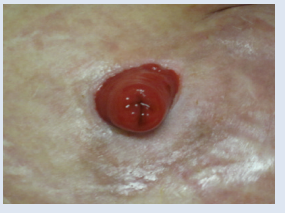
CASE 2

An 83 year old female patient was referred to the Outpatient Ostomy Clinic by her primary care physician for assessment of ileostomy management. The patient had a total proctocolectomy in 2002 for Crohn's disease. She presented to the clinic in a one-piece pre-cut flat pouching system and reported that leakage caused her to change her pouching system 3-5 times a night. The reason for leakage was assessed to be due to a lack of a secure fit around the stoma. Prior to coming to clinic, a rash developed around her stoma that resolved with the use of Nystatin powder prescribed by her primary care physician; however, issues with her pouch leaking continued. The patient had arthritis in her hand and was using a pre-cut one piece pouching system. She was trialed in the moldable pouching system. This elderly woman was able to use the moldable pouching system with her arthritic hands and achieved a consistent 4 day wear time.



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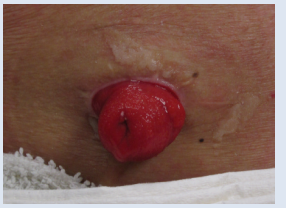
CASE 3

A 43 year old female patient was referred to Outpatient Ostomy Clinic by Urology for hematuria related to lesion/abrasion on the bowel mucosa of her stoma. In 2007, she had a cystectomy with ileal conduit for refractory recurrent urinary tract infections (UTI's) and interstitial cystitis. She reported a 90 pound weight gain after her surgery. The patient was wearing a standard wear cut-to-fit convex skin barrier, with the opening cut too small for her current stoma size. A trial of the extended wear moldable pouching system was initiated. The patient had no further bleeding from her stoma and has achieved a 10 day wear time with the moldable product. No photos are available for this patient.

Case Studies (cont'd)

CASE 4

A 51 year old female patient was referred to the Outpatient Ostomy Clinic from urology. The patient underwent an ileal conduit urinary diversion in December 2004 related to refractory neurogenic bladder and painful bladder spasms. She was confined to a wheelchair due to decreased mobility from myotonic dystrophy, neuropathy, and myopathy and had limited manual dexterity because of multiple surgeries on her hands. On initial assessment, she was unable to change her own pouch due to recent hand surgery and was receiving nursing services three times a day to assist her with care.



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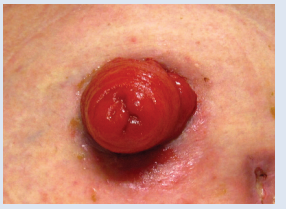
The patient reported her pouching system had been leaking one to two times a day. She was wearing a cut-to-fit skin barrier with a barrier ring. She was unable to empty her own pouch and wore her appliance connected to a leg bag during the day.

There was a small amount of bulging above the stoma and small amount of folding below the stoma that was accentuated with peristalsis. The goal was to provide the simplest pouch change as possible since she had numerous caregivers. The patient was placed in a 2 piece moldable convex pouching system that provided her with a predictable 4-6 day wear time.

CASE 5

A 56 year old female presented to the Outpatient Ostomy Clinic two weeks post-op after a total proctocolectomy with end ileostomy for Crohn's disease in December 2010. She reported her longest wear time as being 3 days, with the pouch leaking 1 to 2 times a day for the 3 days prior to her ostomy clinic visit. Her complaints included that when showering, the pouching system would come loose from her skin. The patient was wearing a 2 piece cut-to-fit pouching system. She was also using stoma paste to fill the space between the stoma and the ostomy appliance. On initial clinic assessment, the patient's skin was denuded from 4-6 o'clock. She returned for a follow-up clinic visit after trialing the moldable skin barrier for 2-weeks and the peristomal lesion had fully resolved. She was very pleased to achieve a 7 day wear time without the use of stoma paste.



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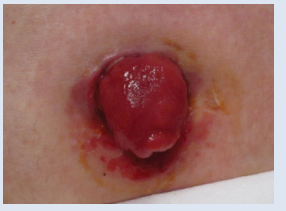
CASE 6

A 60 year old female patient presented to the Outpatient Ostomy Clinic 4 weeks post-op for follow-up and teaching. In September of 2010, she had a low anterior resection with colonic J-pouch to anal anastomosis with diverting loop ileostomy for rectal cancer. The patient reported that she was changing the pouching system every 4-5 days with occasional issues with leakage. She was using a 2 piece cut-to-fit pouching system with stoma paste. The opening in the barrier was being cut to 1 ¼" though her current stoma size was 7/8". Slight dimpling was noted lateral to the stoma. (Note severe denudement inferiorly from 3:00-9:00.) The patient was trialed in the moldable convex pouching system and was educated to crust the denuded skin with stoma powder and water. She lived remotely so she only called for assistance as needed. Upon return for a 6 month follow-up visit to the outpatient clinic, she reports changing her pouch every 4-5 days. She continues to change her pouching system every 4-5 days. She had resolution of her peristomal skin irritation and continued with the moldable pouching system.



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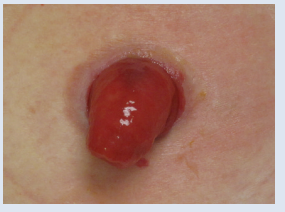

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Conclusion

In A 6-month period, 70 patients, with new and existing ostomies have had appointments for assessment by a certified wound and ostomy nurse (CWON). Approximately one out of every four patients were successfully placed in moldable skin barriers*. Not having to cut skin barriers helped to obtain a more secure fit, which provided a more predictable wear time and decreased trauma to the stoma. The hydrocolloid tape border on the moldable skin barrier helped resolve irritation from acrylic sensitivities for some patients. For optimal patient outcomes, CWON's need to do a comprehensive patient assessment. Keeping current with the technology of skin barriers and pouching systems is essential as product upgrades are frequently developed. For our patient population, moldable skin barriers* have filled the need for a product that can manage many of our patient concerns, and has improved our clinical outcomes such as wear-time and peristomal skin problems.

Sponsored by ConvaTec Inc.

*ConvaTec Moldable Technology™ skin barriers

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