

# Management of a Complex Abdomen on a Patient with Metastatic Colon Cancer

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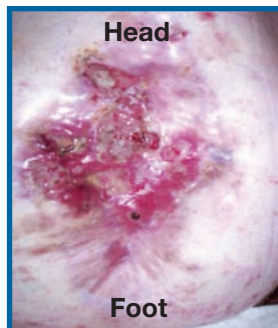
## Introduction

Care of a cancer patient with multiple enterocutaneous fistulas is challenging in many ways. Basic needs of fecal containment, odor control and physical comfort are all common patient concerns. However, those individuals who have abdominal wall metastasis eruption on the skin surface suffer an even greater level of physical and emotional distress.

## Case Study

The patient is a 61 year old male with a history of a mucinous cyst adenocarcinoma of the sigmoid colon diagnosed in 2004. He underwent an exploratory laparotomy and excision of multiple large metastases as well as intraperitoneal chemotherapy. The patient had multiple complications leading to a complete wound dehiscence and eventual skin graft over the bowel.

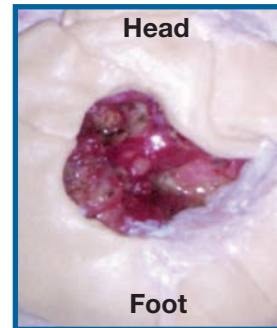
Four years later, he developed abdominal wall metastases with skin breakdown in the previously grafted area. The patient presented to the hospital emergency room with a sudden eruption of feces from his abdominal wall. He was found to have multiple enterocutaneous fistulas in close proximity to the metastatic tumor. The skin surface was uneven and the affected area was larger than standard ostomy pouch systems could accommodate.



Locally advanced mucinous adenocarcinoma of the sigmoid colon. The abdomen is markedly protuberant and skin surfaces irregular. Multiple fecal fistulas erupted at the skin surface.



Malignancy and fistulas in region of previous skin graft. Fragile skin protected with skin bonding latex adhesive.



Irregular surface areas filled and tumor/fistulas bordered with moldable cohesive. Creases were caulked with stoma paste and made waterproof with skin bonding latex adhesive. This leveled the abdominal surface and protected fragile skin prior to applying fistula pouch.



Completed application of fistula pouch. The pouch was bordered with an alcohol skin sealant and waterproof tape to extend wear time.

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### Products:

<sup>a</sup>Eakin® Fistula Pouches and Eakin Cohesive® Seals. Eakin and Eakin Cohesive are registered trademarks of T.G. Eakin Limited.

<sup>b</sup>Cavilon® No Sting Barrier Film. Cavilon is a registered trademark of 3M Company.

<sup>c</sup>Adapt® Paste. Adapt is a registered trademark of Hollister Inc.

<sup>d</sup>Torbot™ Liquid Bonding Cement. Torbot is a trademark of Torbot.

<sup>e</sup>Hy-Tape® Adhesive Tape. Hy-Tape is a registered trademark of Hy-Tape Surgical Products Corp.

<sup>f</sup>New Image® Ostomy System. New Image is a registered trademark of Hollister Inc.

<sup>g</sup>Miconazole nitrate 2%. HealthPoint.

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## Clinical Approach

A discussion was held with the patient and family, and therapy goals were established. Their goals were:

- fecal containment
- odor control
- comfort
- ability of the patient to return to home

An initial attempt was made to fit the patient with a standard 4” two piece drainable pouch system<sup>f</sup> and cohesive seals<sup>a</sup>. This approach proved problematic in that the surface of the skin was changing on a daily basis and the rigidity of the barrier could not conform to his rounded abdominal contours. Additionally, the pouch system was not large enough to entirely contain the fistulas without traumatizing the adjacent tumor.

Consequently, specialty fistula pouch systems were researched and samples were received from an ostomy manufacturer. To apply the pouch, the skin and tumor were washed with normal saline and allowed to completely dry. A washable, non-alcohol skin sealant<sup>b</sup> was then applied to the intact skin. An ostomy cement<sup>d</sup> was used to further protect fragile skin from adhesive products and from washing of effluent over its surface. Uneven contours were leveled with cohesive seals<sup>a</sup> and seams caulked with stoma paste<sup>c</sup>. The seams were then painted with ostomy cement<sup>d</sup> to further waterproof the spaces. The center of the specialty pouch was cut to accommodate the fistulas<sup>a</sup> and applied to the patient’s skin. The edges of the system were then caulked with paste<sup>c</sup>, sealed with cement<sup>d</sup> and bordered with waterproof tape<sup>e</sup>. The fistula pouch system was changed twice a week.

## Patient Outcomes

The CWOCN was able to assist the patient and family in meeting the goal of returning home. Pouch changes continued twice a week and as needed for 5 weeks. During that time, the patient was able to make a final visit to a favorite lakeside park and receive visitors in his home as his health declined. Fecal containment was achieved and comfort was reached with the help of systemic analgesics.

As his health failed, the patient was again hospitalized and pouch changes continued as scheduled. He developed candidiasis that was treated with topical antifungal powder<sup>g</sup> and a skin sealant<sup>b</sup>. When he became bedridden, his wife agreed to allow the fistula pouch to be connected to wall suction. This prolonged the wear time of the system and promoted his overall comfort. When the patient expired, the pouch was left in place at the request of the funeral home director to contain any body fluids and to prevent soiling of his clothing.

## Conclusion

It is the perception of the family that it was the support of the CWOCNs and the use of specialty fistula pouches that allowed the patient to return home and have quality time with his family prior to his death.

### ***Quote from Surgeon’s History and Physical Dictation:***

“The only thing that I can imagine that will help in the near term is an abdominal binder and a large stack of terry cloth to be changed when one becomes saturated with stool. Attempts to tape ABD pads which are not absorbent enough would, I think, be a failure”