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. 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.

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.

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.
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.

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*ConvaTec Moldable Technology™ skin barriers
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