PRODUCT SOLUTIONS

Case Study Using Adapt Barrier Rings for Mucocutaneous Separation

Overview

G.P. is a 66-year-old woman who was diagnosed with a low rectal tumour in May 2008. She underwent an abdominoperineal excision of the rectum (APER) two months later, and her recovery was uneventful. She was discharged from the hospital 10 days postoperatively, and was followed up closely by the Stoma Care Nurse in her community. Within two weeks of discharge, problems arose with the perianal wound and urgent re-admission to the hospital was required. The perianal wound had completely dehisced (opened), making visible the vault of the vagina and a cavity that could accommodate two adult fists.

A combination of treatments, including vacuum-assisted wound therapy and plastic surgery, were utilised to bring about secondary wound closure. This regimen took four months before the wound healed.

Six months later, G.P. went to her local hospital complaining of crampy, abdominal pain and colostomy inactivity. A subacute bowel obstruction was diagnosed. The surgeons felt that conservative management would restore bowel function and, indeed, this initially seemed to be the case. However, just 72 hours following discharge, G.P. was re-admitted to the hospital due to a complete bowel obstruction.

A second laparotomy was performed, at which time the abdominal cavity and major organs (i.e., liver and lungs) were found to be encased with a solid tumour. A palliative resection was the only surgical option along with the fashioning of an end ileostomy, done so to bypass the obstructing colonic tumour.

Problem:

G.P. was unable to cope with this new type of stoma. It was unfamiliar to her and the idea of draining a pouch repulsed her. The ileostomy had been constructed from proximal ileum and the output was consistently greater than 1400 mL daily. Various appliances, including convex pouching systems, had to be trialled due to leakage problems. G.P. felt uncomfortable with this style of pouch as it felt rigid and did not conform easily to body contours or the multiple skin defects that resulted from her preoperative weight loss. Pouch leakage made G.P. feel very fearful and anxious.

Two days postoperatively, she developed circumferential parastomal cellulitis. Tracking appeared on the right lateral aspect of the ileostomy with substantial erythema and swelling. Three days postoperatively, an area of mucocutaneous separation and an area of necrosis appeared. At this point, there was no oozing or seepage of fluid from the two sites, but concern remained with regard to the appearance of the peristomal skin and the unresolved erythema.

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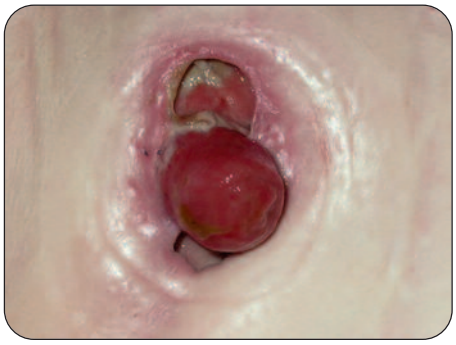

Two detached areas are visible around the mucocutaneous junction.

Both cavities are packed with an alginate dressing.

Alginate is occluded with the Hollister Adapt Barrier Ring and Adapt Paste.

Three weeks after treatment. The cavities are greatly reduced.

G.P. was discharged back into the community, where the Stoma Care Nurse monitored her progress daily. Within four days of discharge, there was pus emanating from the mucocutaneous junction and the area of necrosis was demarcating. The latter was manually debrided with a surgical blade. Two cavities now existed, making pouch management and product adhesion difficult.

Solution:

Daily stoma dressings were required to control and manage the high volume of exudate being produced by the two cavities. The cavities, once cleansed with normal saline, were packed with a seaweed-based alginate dressing. Both the cavities were packed so the alginate lay flush with the abdominal surface.

The peristomal skin and the two cavities (filled with the alginate dressing) needed to be made waterproof to prevent faecal effluent from contaminating the dressing. A Hollister **Adapt** Barrier Ring was applied over the dressings for occlusion purposes. The Adapt Barrier Ring fit well against the dressings and skin allowing flexibility of movement and enabling 24 hours of wear time.

A small amount of Hollister **Adapt** Paste was applied around the stoma to enhance the seal between the stoma and the pouch. A Hollister **Moderma Flex** Drainable Pouch was chosen due to its soft, flexible, and low-profile properties. G.P. expressed that it felt comfortable next to her skin and she liked the security and ease of the **Lock 'n Roll** closure.

Outcome/Conclusion:

G.P.'s stoma care was successfully managed at home due to the simplicity of the stoma dressing. The frequency with which the pouching system had to be changed was greatly reduced. G.P. was able to socialise with friends and family and take her granddaughter to school. Her confidence increased very quickly, primarily due to the eradication of leakage. The two cavities that were causing concern healed within four weeks.

In a recent review of G.P.'s peristomal skin, circumferential epithelialized tissue was evident. In the future, following complete healing of the mucocutaneous junction, it is anticipated that G.P. will only require the Moderma Flex Pouch without the use of additional accessory products.

Hollister gratefully acknowledges the assistance and caring of Stoma Care Specialist Nurse Elaine Cronin, St Mary's Hospital, London, UK

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