

Name: Jennifer Bonick

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Remediation Ostomy Management Essay Final Exam

This is a remediation final exam developed based upon your previous objective final quizzes. This exam is developed to further enhance understanding of concepts in Urinary and Fecal Diversion Management.

A score of 80% or higher is required for passing this exam. Your answers should be scholarly, including complete sentences. Should you feel the need to research the concepts, please be sure to include references and citations as appropriate. The possible points awarded for each question varies and is indicated with the question. APA formatting will be considered in final score. Good Luck!

1. You are consulted to begin teaching a patient with a continent reservoir (Indiana pouch). Describe teaching components to be considered including how the reservoir was constructed and why. (5 points).

An Indiana pouch is considered as a surgical option when the bladder must be removed for medical reasons such as bladder cancer, neurogenic bladder, or trauma. The bladder is absent, and a new pouch is created to replace it and work in a similar way that the bladder did to store urine. The Indiana pouch is a catheterizable continent pouch that uses the ileocecal valve as the continence mechanism. (Llueca et al., 2020). The pouch is created by taking approximately 60 cm of ascending colon and also the transverse colon to create a pouch or “bladder”. Approximately 12 cm of terminal ileum is used to bring a stoma up to the skin. (Llueca et al., 2020). The pouch connects to a piece of the intestine that is being used as the urethra or the continence mechanism. Teaching points to consider are that the patient must have manual dexterity and vision that is intact enough to be able to catheterize the stoma. Explain to the patient that the time in between each catheterization will gradually get longer as the pouch reaches capacity.

Llueca, A., Maazouzi, Y., Ponce, P., Serra, A., Garau, C., & Rodrigo, M. (2020). Step by step Indiana pouch construction in a previously irradiated patient with a cervical cancer relapse. *International Journal of Surgery Case Reports*, 66, 187-191. <https://doi.org/10.1016/j.ijscr.2019.11.068>

2. You are consulted to see a preterm infant with a new ileostomy and mucus fistula. In considering pouching options, you know there are specific skin differences between this population and the adult population. Explain the skin differences and the considerations to choosing a pouching system for this infant. (2 points)

Preterm infants have an underdeveloped dermis and epidermis which leads to them having an increased absorption of topical medications. (Uzsen et al., 2021). Having an underdeveloped dermis and epidermis leads to an increased risk of irritation and peristomal skin breakdown due to the skin being so fragile. Pouching concerns for the preterm infant include using a smaller pouching system if needed and also attempting to pouch the ileostomy and the mucus fistula together, if possible, to eliminate increased potential skin irritation from pouching system. A common practice is placing a cotton ball in the pouch

system to assist with absorption of effluent. If the ostomy (usually not recommended for an ileostomy) does not have a lot of output, it is possible to have the stoma drain into the diaper of the infant as long as the skin is protected and monitored for any skin breakdown. The pouch recommendation for wear time is 12-24 hours with frequent assessment of skin and appropriateness of pouching system.

Uzsen, H., Yaz, S., Gumus, M. (2021). The Effect of Ostomy on Pediatric Patient and Family in Nursing: A Systematic Review. *Journal of Pediatric Surgical Nursing* 10(4):p 153-158, <https://doi: 10.1097/JPS.0000000000000313>

3. For each peristomal skin problem, provide a definition (clinical characteristics) and treatment/pouching technique. (2 point for each/8 total):

a. Pseudoverrucous lesions- pseudoverrucous lesions are wart like papules that present with a white or gray hue to them. There is an overgrowth of tissue that is caused by a chronic irritation that is often seen with urinary stomas. This constant irritation causes thickened skin to develop which can then tend to bleed easy. Pouching considerations include ensuring that the patient has a proper fitted pouching system that will decrease the risk of moisture causing damage to the skin. Another option is to ensure that the patient is using stomadhesive powder and also no sting skin barrier wipe to seal. Depending on the amount of skin damage to the peristomal area, the patient may also benefit from a duoderm to protect the irritated skin and then attaching the pouching system to the duoderm. This will help to prevent further damage to the skin and leakage from irritated skin and increased moisture. If the patient has exhausted treatment options and they are not improving, stoma relocation may be a discussion.

b. Peristomal varices (caput medusa) – peristomal varices are a dangerous complication of blood vessels that presents as a bluish / purple discoloration to the peristomal skin. They develop between the intestinal stoma and the abdominal wall vasculature. (Gowda et al., 2020). This bluish discoloration represents blood that is shunted to develop adhesions of the abdominal wall typically due to the patient suffering from chronic liver disease. (Gowda et al., 2020). The bleeding may be significant in nature. Applying direct pressure to the site of bleeding to control the amount of bleeding. A concern with pouching is to avoid any further trauma to the area of varices. Additional trauma to this area can cause bleeding. If the patient is able to have a non-adhesive pouching system, that may be an option as well due to the decreased risk of skin irritation if there is no adhesive. An important teaching point with these patients is that if they are at home and their varices start to bleed, the patient will need to call 911.

Gowda,s., Sethi, P., Motapothula, U. (2020). Peristomal variceal hemorrhage at the ileal conduit site due to extrahepatic portsystemic shunt. *Indian Journal of Urology*.36:130-132. https://doi: 10.4103/iju.IJU_292_19

c. Suture granuloma- A suture granuloma is an inflammatory response of our body in reaction to suture material that is retained. (Michalak et al., 2023). The issues that granulomas present are with obtaining a good seal with the ostomy pouching system. The tissue surrounding a suture granuloma can be friable and moist which affects the adherence of a pouching system.

Silver nitrate or electrocautery are options to help control the bleeding and excessive granulation tissue that may start to grow due to the suture granuloma.

Michalak, J., Spitler, C., Simman, R., Sharp, K., & Pei, M. (2023). Stomal and peristomal complications management: a retrospective study. *Journal of Wound Care*, 32(1), 35-42.

<https://doi.org/10.12968/jowc.2023.32.1.35>

d. Fungal dermatitis – Fungal dermatitis presents in a patient with pain and itching. The patient will also have satellite lesions that resemble white small pustules on the surrounding peristomal skin. (Michalak et al., 2023). Treatment for this type of dermatitis includes determining what the source of the irritant is. Also finding out how often the patient empties their pouch, changes their pouching system, and what the wafer looks like when they remove the wafer will give a good indication of how to best treat this type of skin condition. When assessing the peristomal skin, the nurse should determine if the patient is in a proper fitting pouching system. An antifungal powder is effective in addition to using a no sting skin barrier wipe to seal the powder and create a “crusting” that will help protect the skin. If the fungal dermatitis is severe or resistant to the antifungal powder, the patient may need systemic antifungal medication.

Michalak, J., Spitler, C., Simman, R., Sharp, K., & Pei, M. (2023). Stomal and peristomal complications management: a retrospective study. *Journal of Wound Care*, 32(1), 35-42.

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3. Identify and describe the symptoms, diagnosis, and treatment procedure of an ileal blockage. An ileal blockage occurs when there is a small bowel obstruction noted caused most likely from a food bolus. This can be a partial blockage or even a complete blockage. The patient will usually present with complaints of decreased effluent from their stoma or abdominal pain. The patient may also notice edema of the stoma. IF the blockage is caused by a food bolus, it can attempt to be gradually dislodged with saline instillations. The care provider must ensure that the blockage is not caused by something else. A mechanical obstruction is a dangerous obstruction that is caused by adhesions, severe edema, or a volvulus. If the nurse suspects a blockage, a lubricated gloved finger can be inserted into the stoma opening to see if a food bolus can be felt. If so, it can be gently broken up if possible. A lubricated 14-16 french catheter can be inserted into the stoma opening. Slowly instill 30-50 cc of normal saline into the catheter using a bulb syringe may be used. The catheter should then be removed to allow for return. This procedure may be repeated by instilling 30-50 cc at a time until the blockage is resolved. This may take 1-2 hours. The patient can also be instructed to change their pouching system to allow for edema of the stoma. The patient can also be instructed to take a warm shower or bath to assist with relaxation of abdominal muscles. The patient should be instructed to avoid eating food but may continue to drink as long as there is still some output. If there is no output, the patient should remain NPO. The patient should be instructed to go to the ER if they have no output as they may have a complete obstruction. (Berti & Elliott, 2019).

then there will also be a secondary return. The patient should be taught to wait for this second return. If the patient is not noted to have return right away, instruct the patient to wait up to 30 minutes. This is important so that the patient does not start to needlessly worry.

7. Explain what is meant by increased transit time and what is meant by decreased transit time? (1 points).

Increased transit time is referring to the time of food to be eliminated once it enters the mouth being less time than the normal range. These patients may suffer from frequent bowel movements, incomplete absorption of electrolytes, and abdominal cramping. A decreased transit time is a delay in the time it takes for to move from the mouth and be eliminated through the anus. When there is a decreased transit time, the patient may suffer from constipation, abdominal pain, bloating, and also even blockages due to increased stool burden mixed with constipation.

1. Identify the abdominal quadrant one would expect to find the stoma type to be located. (2 points)

- a. Ileal conduit - usually in the lower right abdomen
- b. Colostomy – usually in the left lower abdomen – transverse colostomy would be more in the middle or right side and ascending colostomy would be on the right side
- c. Ileostomy – usually in right lower abdomen, may be lower left
- d. Urostomy -usually in the right lower abdomen