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Original Research Paper

Surgery

HANGING ILEOSTOMY

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KEYWORDS :

Ileostomy is one of the most commonly performed procedures in abdominal surgeries for a wide range of indications from emergency to elective setting. It may either be constructed as an end or loop ileostomy.

The traditional technique is to create a spout of 3-4 cm by everting the full thickness of the bowel [1]. This is important while making an ileostomy to collect the effluence in the appliances and to prevent skin excoriations. However, as commonly faced by many surgeons, eversion is not always easy or not possible. This occurs when the bowel is too edematous or patient is obese with short ileal mesentery or those with inflammatory bowel disease and in such patients, complication rate close to 24% is reported [2]. This new technique of creating an ileostomy in such difficult situations, is a simple efficient get away solution in such a clinical scenario.

Technique-

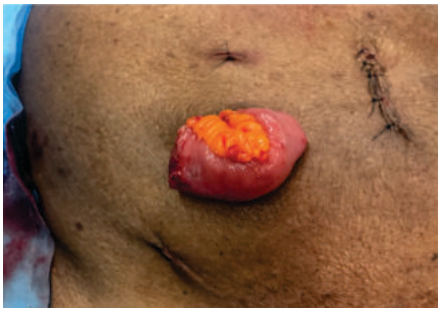
Skin incision made at pre planned site and rectus sheath and muscle divided open. If an attempt to evert the bowel fails or the mesentery length does not permit it, a hanging ileostomy is made. The end of the ileum is brought out of the skin wound for approximately a length of 5-6 cm from the skin surface. The serosa is fixed to skin with circumferential interrupted absorbable sutures about 5-7 mm apart. As an additional safety measure on may place 2-3 absorbable sutures between bowel serosa and rectus sheath if there is no sufficient sprout or if there is a tendency to retract. In case of loop ileostomy, the bowel is completely divided and the proximal loop is hanged as described above. Distal loop is circumferentially fixed flush to the skin as described above.

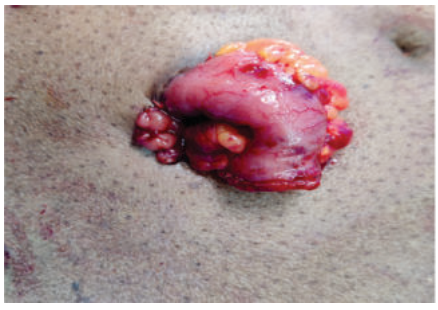
The post operative management of stoma is the same as that of everted stoma. At 8 weeks follow up, the serosa is seen to be covered with mucosal lining and appears indistinguishable from conventional ileostomy.

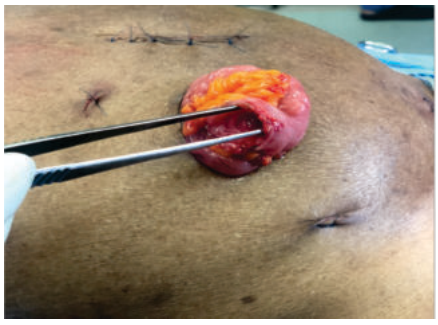
We have performed this type of stoma in 54 patients with technique and have complete follow up. Of these patients, 39 were performed in an emergency setting following intestinal obstruction and perforation peritonitis wherein the bowel and mesentery are edematous making eversion of bowel very difficult. This is particularly very common with patients with inflammatory bowel disease like Crohn's disease where the mesentery and bowel are very thick. Elective indications were those who required diversion ileostomy following rectal surgeries, usually in obese patients where mesentery is bulky and short.

Only disadvantage of this technique is that as the bowel side suture to skin is not full thickness, some sutures can give way in the initial few days of surgery and may need additional reinforcement sutures under local anesthesia, however we have found this issue a very unusual occurrence.

Use of an ileostomy rod is another popular method adopted by many units to prevent stomal retraction and associated complications. However, recent metanalysis have failed to show any benefit of use of stomal rods in preventing stomal retraction or peristomal dermatitis [3]. Hence, we encourage to use hanging type non-everting stoma in clinical situations when bringing out of the bowel and eversion is difficult.







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