



Analysis of Complications of Intestinal Stomas

KEYWORDS

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ABSTRACT This study was aimed to evaluate the complications of intestinal stoma surgery in a strictly followed patient population of our hospital.

INTRODUCTION

An intestinal stoma is an opening of the intestinal tract onto the abdominal wall, constructed surgically or appearing inadvertently. Stomas are created to make possible for patient to live near normal life in spite the pathology present. Stomas can be temporary or permanent, loop or end depending on pathology and need for construction. This study was undertaken with objective to study different complications and sequel of stoma formation.

MATERIAL AND METHODS

This is a prospective observational study conducted at department of surgery GCS Hospital, ahmedabad. A study of fifty cases of intestinal stoma was carried out between June 2013 and September 2014. The required information was gathered from case papers of patients admitted and operated in this hospital, over the mentioned time period

DATA COLLECTION: The cases studied were categorized according to; Age and sex of patient undergoing the procedure, The primary pathology or indication for stoma formation; The setting in which the procedure was performed i.e. emergency or elective; Type of stoma and nature of stoma.

Complications were categorised as intraoperative, post-operative and complications of stoma.

OBSERVATIONS:

The following results were obtained from the study of 50 patients, who undergone stoma surgery for various indications in our hospital from June 2013 to September 2014. From this study two peaks in age distribution are found. First in age group 21-40 and second in age group 41-60 yrs. In this study we found 58% of patients undergone stoma surgery was males and rest 42% were females. Ostomy surgery was done mostly in emergency setting (76%) as compared to planned surgery (24%). Stoma closure; All stomas were closed between 6 weeks and latest after 10 weeks

Table 1: Type of stoma:

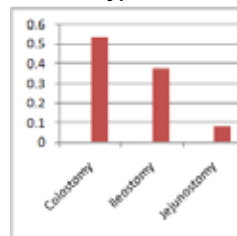
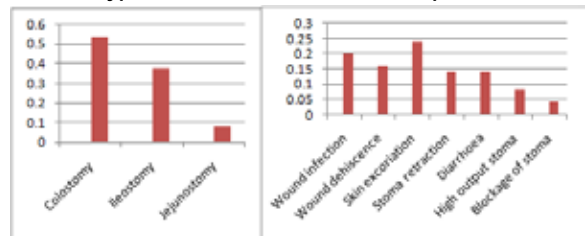


Table 2: Complications:



DISCUSSION:

Stoma is external opening over abdominal wall of a part of bowel lying inside abdominal cavity. Stoma is named by prefixing the name of part of bowel from which it originates like jejunostomy, ileostomy, cecostomy and colostomy.

TYPES OF STOMA:

On basis of duration: Temporary stoma / Permanent stoma

Surgical classification: End stoma / Loop stoma / Double barrelled stoma (Paul Miculicz) Split stoma / Trepine stoma

Anatomical classification: Cecostomy / Jejunostomy / Ileostomy / Colostomy.

Ill prepared or ill managed stoma can result in serious complications. These complications can lead to deterioration in patient health and psychological wellbeing. Preoperative assessment and stoma site marking, postoperative education and follow-up visits are helpful in preventing complications. Complications may be early or late. Early complications are those which occur within thirty days of surgery.

Complications may be

TYPE	Early	Late
STOMAL COMPLICATION	Poor location Retraction Ischemic necrosis Mucocutaneous separation Stomal trauma Abscess formation Opening wrong end	Prolapse Stenosis Retraction Parastomal hernia Fistula formation Gas Odour
PERISTOMAL COMPLICATIONS	Excoriation Dermatitis Pyoderma gangrenosum	Parastomal varices Dermatitis Dermatoses Cancer Skin manifestations of inflammatory bowel disease
SYSTEMIC COMPLICATIONS	High output	High output Bowel obstruction

CONCLUSION:

This study suggests that, stoma was performed mainly in the age group of 41-60yrs and majority of patients were male. Temporary stomas were performed more commonly as compared to permanent stomas. Majority of stomas were performed as emergency surgery; so as to decompress distal bowel, or to divert fecal stream from distal bowel segment (as to protect RA, Perineal wound or to avoid distal obstruction as in rectal or anal carcinoma). Colostomy was most commonly performed surgery, followed by ileostomy.

Results suggests that skin excoriation is most common complication seen, followed by surgical site infection, wound dehiscence, diarrhoea and stoma retraction (patients lost to follow up were not included in study). Peristomal skin excoriation was common, probably due to lack of specialized stoma management. Stoma closure should be done after 8-10 weeks to minimize the morbidity and mortality. This period of time is generally enough for recovery, infection control and improvement of local abdominal wall conditions.

In case of doubt regarding the performance of a primary anastomosis, surgeon should choose ostomy, as experience shows mortality is lower when it is performed during first operation as compared to second surgery.

The construction of stoma requires adequate preoperative preparation in the form of counselling and preoperative stoma site marking, so as to avoid many of complications which can be quite distressing to the patient and surgeon alike.

In conclusion, a team approach involving the surgeon, ostomy staff nurse, and ostomates is essential in this type of surgery. However, considering such a small number of study cases over a limited period of time in a single institution, results of such a study cannot be generalised. Follow up and continuing care is stressed, especially in permanent stomas.

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