

Peristomal Skin and Ostomy Care

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Astoma is an opening and an ostomy is a surgically created opening, either temporary or permanent, used to divert the flow of stool or urine. A pouch collects the urine or stool and has a solid skin barrier, also referred to as a wafer, that adheres to the peristomal skin. Peristomal skin, the skin surrounding a stoma, is an important part of ostomy care. The ostomy pouching system's adherence is dependent on healthy, dry, intact peristomal skin and a properly fitted pouch.

Peristomal wounds can be difficult to manage for patients and clinicians. Moisture and effluent from an ill-fitting pouching system can cause skin breakdown and wounds in the peristomal skin. Interventions to treat wounds include dressings that will fill the dead space in the wound, absorb wound exudate, maintain a clean wound bed, and achieve predictable wear time of the pouching system (at least 24 hours). Wounds with minimal exudate may be treated with stoma powder for moisture control. Wounds with moderate to large amounts of exudate need to be treated with an absorbent dressing to manage exudate and fill dead space and covered by a secondary dressing.

Choosing a secondary dressing with a semi-occlusive backing to maintain a dry pouching surface will prevent moisture from migrating through the outer cover. Dressing change frequency depends on the amount of wound exudate. A wound with excessive drainage may need to be changed daily; a wound with minimal exudate may only need to be changed two to three times per week.

The patient with a peristomal wound requires ongoing physiologic and emotional support throughout treatment. Families and nursing staff also require support in managing peristomal complications and wounds. ■

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Commentary By Ferris Mfg. Corp.

Addressing peristomal skin complications with appropriate skin care is crucial to the success of an ostomy pouching system. In a representative case study,¹ a 68-year-old man developed a Stage III ulcer adjacent to his urostomy, secondary to pressure and shear from his urostomy bag wafer. After 18 months, the ulcer measured 1.9 cm x 1.2 cm x 0.2 cm and comprised 10% necrotic and 90% friable granulation tissue with moderate amounts of serosanguinous exudate. The surrounding skin was macerated and erythematous. After sharp debridement, multifunctional PolyMem Silver® Dressings were applied and then covered with a hydrocolloid dressing that also went around the stoma to hold the urostomy wafer in place. PolyMem Silver was applied to decrease the bioburden, promote healing, and prevent urine leakage onto the periwound area. The ulcer closed 60% in the first week of the new protocol. After initially closing, the ulcer closed and re-opened four times. After re-closing the ulcer for the fourth time, the clinician continued use of the PolyMem dressing without silver on the closed ulcer for 4 weeks in order to strengthen the scar tissue. The ulcer did not recur. ■



May 3: A peristomal pressure ulcer is 60% smaller after 1 week of PolyMem use.



November 29: After re-opening four times, the ulcer remained closed once PolyMem dressings were kept on the closed ulcer for an additional 4 weeks to strengthen the new epithelial layer.

Reference

1. Jacob N. Long-Stalled Pressure Ulcer at Ostomy Site Closes Quickly Using Thin Cleansing Absorbent Dressings. Poster presented at the 23rd Annual Clinical Symposium on Advances in Skin and Wound Care. Las Vegas, NV. October 26-30, 2008.

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