PRODUCT SOLUTIONS

Case Study Using the Adapt Barrier Ring for Stomal Bridges/Rods

Overview

L.P. is a 74-year-old woman who was admitted to the hospital via her local accident and emergency department. She presented with symptoms of crampy abdominal pain, abdominal distension, diarrhoea, and vomiting. She claimed to have had these symptoms for seven months. She was diagnosed with adenocarcinoma of the rectum. The large mass in her rectum had proliferated beyond the confines of the bowel wall and had metastasised to the liver and lungs.

L.P. was deemed palliative due to her already extensive abdominopelvic disease. She was scheduled for a laparoscopic defunctioning colostomy to relieve her obstructive symptoms and aid bowel decompression. L.P. was resigned to the fact that surgery was necessary and said that she "didn't mind having a stoma, so long as it got rid of the diarrhoea."

Problem:

Following surgery, L.P. was weak and her energy level was low. A blood test showed her albumin was only 18, owing to poor caloric and nutritional intake for many weeks prior to hospital admission (the normal value ranges from 30–35). L.P. was living alone and was anxious about how she would cope at home with her colostomy.

On the fourth postoperative day, she developed generalised oedema and her whole abdomen felt tight. The bridge/rod, which is used to support a loop stoma during the early postoperative period and is usually removed 5–7 days postoperatively, was immobile. The surgeons requested that it remain in place for a further 7–10 days, or until such time as the abdominal oedema had subsided. It was felt that premature removal of the bridge/rod could precipitate stomal retraction.

The prongs or 'T' bars, which form part of the bridge/rod, were causing indentations in the peristomal skin and there was risk of pressure ulceration. Pain also was experienced around the stoma. The tightness and immobility of the bridge meant that there was insufficient space with which to slide the flange into position and, thus, pouch security was compromised.

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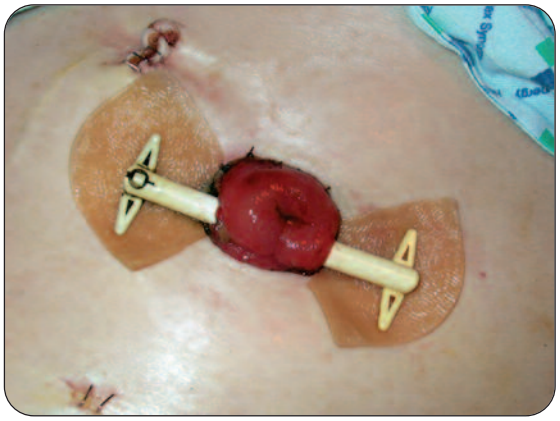
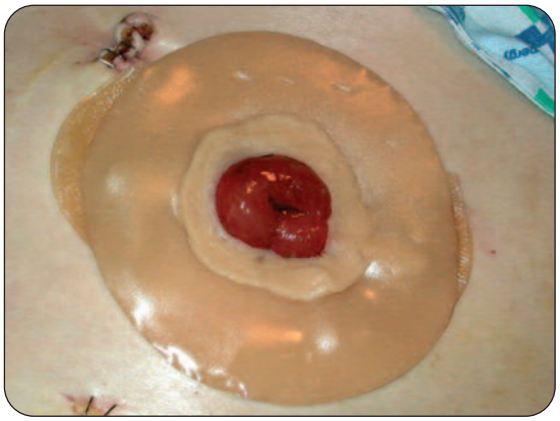


The prongs/'T' bars are cushioned by a hydrocolloid dressing.



The bridge/rod is occluded by an Adapt Barrier Ring, and Adapt Paste applied around the stoma.

Solution:

A thin layer of hydrocolloid dressing was applied where the prongs/'T' bars from the bridge/rod made contact with the peristomal skin. This acted as a cushion.

The entire bridge/rod was then draped with a Hollister **Adapt** Barrier Ring (occluding the bridge completely) and **Adapt** Paste was applied around the stoma. This allowed the Hollister **Moderma Flex** One-piece Drainable Pouch to be snugly applied over the Adapt Barrier Ring, increasing total wear time of the ring, paste, and pouch to 3-4 days.

The benefit of this approach was that L.P. (who could not cope with too much intervention at this stage) could be left to rest for a longer period and her disturbance was kept to a minimum.

Outcome/Conclusion:

Comfort was achieved around the stoma site, pressure ulceration was averted, and the appliance was fitted snugly with wear time extended to 3-4 days. The area felt more comfortable, and little by little the oedema began to dissipate. The mucocutaneous junction remained intact and the stoma was managed with the Moderma Flex One-piece system.

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

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