

Prolapse & retraction

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There are a number of complications that can occur with people who have a stoma. These can include a prolapsed stoma and a retracted stoma. Jennie Burch is an Enhanced recovery nurse facilitator at St Marks Hospital, Middlesex and she explores these two topics so Tidings readers can understand how to care for their retracted or prolapsed stoma if it should occur.

Jennie Burch writes:

What is a prolapsed colostomy?

A prolapsed colostomy is a colostomy that has grown longer, telescoping out of the body; sometimes quite suddenly. People with a transverse colostomy have more risk of having a prolapsed stoma. The colostomy will look larger and may even completely fill the stoma bag.

How common is a prolapsed colostomy?

It is reassuring to know that a prolapse is not very common. The incidence of a prolapsed stoma within the first three weeks of the stoma being formed is low, happening in less than one in every 100 patients with a stoma.

In the longer term, there is more chance of a stoma prolapsing. About one in four people with a loop transverse colostomy will experience a prolapse. For people with an end colostomy this risk is much less with about three in every 100 patients reporting a prolapse.

Why does a prolapse occur?

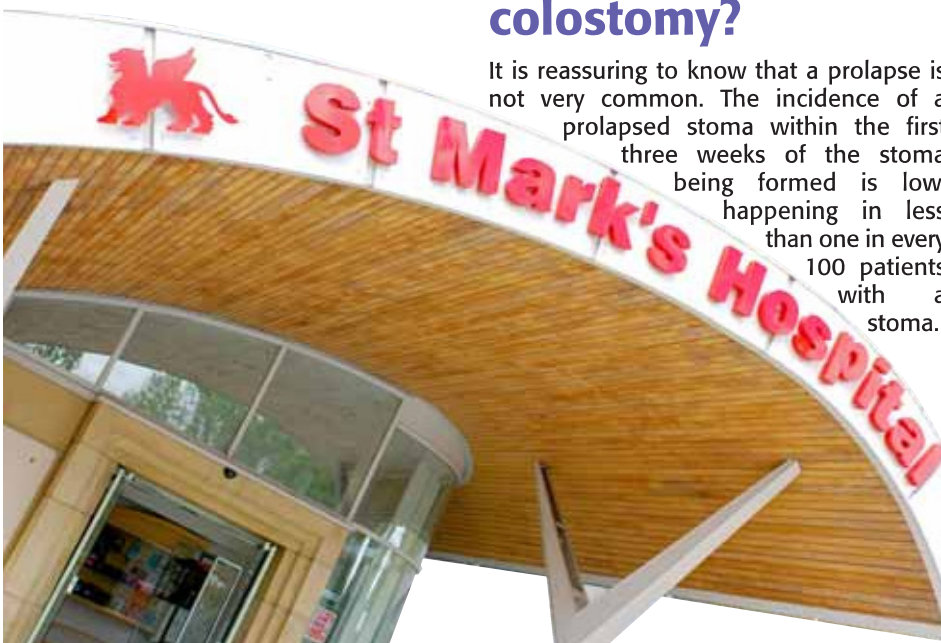
There may be no reason for the prolapse to happen. Alternatively it may be a result of increased abdominal pressure or pregnancy.

How to look after a prolapsed stoma

It is advisable to book an urgent appointment with the stoma specialist nurse the first time that a prolapse occurs. At this meeting the nurse can assess the stoma, the skin around the stoma and the appliance that is being used. Sometimes the appliance size may need to be changed at this visit. If the prolapse is very long a larger bag may be necessary to contain the prolapsed stoma and the faeces.

One possible treatment for a prolapsed stoma is the manipulation of the stoma back inside the body. Do not attempt this without explanation and instruction from a stoma specialist nurse or a doctor. Manipulation of the prolapsed colostomy back inside the body can be performed with the help of a cold compress or sugar.

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Using sugar can be messy and should only be used if assessed as appropriate by a health care professional.



Prolapsed colostomy

If a prolapse will not stay inside the body, you should check it regularly at each bag change for:

- A change in colour – becoming darker or black requires urgent medical attention.
- Bleeding – this may occur as the bowel is now larger and thus more at risk of being knocked accidentally. If there is bleeding a gentle pressure will usually stop the blood flow. If bleeding will not stop then urgent medical attention is necessary.
- Lack of faeces and flatus from the colostomy. Call the stoma specialist for advice. Explain how long the stoma hasn't worked for, if this has happened before, if your stomach seems swollen/distended, if your stoma has changed colour or if you are experiencing any abdominal pain.

A trick for looking after a colostomy that is 'normal' in size sometimes and that is prolapsed at other times is to 'feather' the inner edge of the flange. This is achieved by making small cuts into the inner edge of the appliance adhesive before it is adhered to the abdominal wall.

In other situations the prolapse may disappear back into the body during the night and in this case a stoma shield can be used. The shield is a small, half egg shaped, plastic cover used over the colostomy bag/appliance. The shield is held in place by a small elastic belt and helps to prevent the prolapse from occurring during the day.

If there are problems with the colostomy prolapse being excessively large or other issues occurring such as bleeding, an operation may be necessary. Generally people can manage a prolapsed colostomy without surgery.

What is a retracted colostomy?

A colostomy can be considered retracted if it is below the level of the abdominal wall. When forming a colostomy it is now thought that it should be slightly raised above the abdominal wall by about 10mm. Research has suggested that a colostomy that is raised about 10mm tends to have fewer problems compared to ones formed shorter.

The incidence of any type of stoma being retracted stoma within the first three weeks of the stoma being formed is about 14%. This means that about 1 in every 8 people with a stoma will have a retracted stoma. In the longer term there are fewer reports of people with a colostomy having a retracted colostomy; up to 6% of people.



Retracted colostomy

A retracted colostomy might result in faeces creeping under the adhesive part of the stoma flange/baseplate. This can result in the skin becoming sore or the appliance leaking.

Why does a colostomy retract?

Sometimes it is difficult for surgeons to form a colostomy for a variety of reasons. This may result in tension on the stoma that pulls it back into the abdomen.

Another uncommon reason that the stoma might become retracted is because of problems soon after the operation. Problems include the skin and the stoma becoming detached. Other terms that can be used to describe this occurrence include stoma separation, mucocutaneous separation or mucosal separation. Once healing has occurred the stoma might become retracted.

Also if the stoma was dark or necrotic after the operation this may also result in the stoma becoming retracted. Although luckily, this is quite a rare occurrence.

Weight gain after an operation can also result in the colostomy becoming retracted. This is because the stoma remains in the

same place but the abdominal wall expands around it.

How to look after a retracted stoma

If the stoma is retracted it should be assessed by the stoma specialist nurse. There are a number of stoma products that can be tried, including a stoma seal, a convex appliance or a stoma belt. For some people losing weight may be a solution.

A stoma seal can also be called a washer. There are many different types. Some are stretched to fit and others are made in different sizes. The stoma seal adds a little extra thickness directly around the stoma and under the appliance. This thickened area helps the appliance to stick better to the abdominal wall.

A convex appliance is shaped as a small dome that pushes into the abdominal wall. This pushes the skin around the stoma in slightly, which pushes the retracted colostomy out slightly. This helps to improve the adhesion of the appliance and prevent it from leaking. Convex appliances need to be used with caution as the pressure from the dome shape can cause bruising or in extreme situations ulceration. Bruising or ulceration is rare but at each appliance change the skin should be checked for any signs of damage. If ulcers occur an urgent review by the stoma specialist nurse is necessary.

A stoma belt can be used in conjunction with a stoma appliance. It is a thin elastic belt that is clipped to the edge of the appliance and holds the appliance more securely to the abdominal wall. The belt should be as tight as undergarments. The belt should be worn level with the stoma appliance and not on the waist. Often the stoma belt is used in conjunction with a convex appliance for increased security. The belt can be hand washed and reused as necessary.

If assessed to be necessary a surgical revision of the retracted colostomy may be needed. However for most people this is not required.

Conclusion

To summarise, although a prolapsed or a retracted colostomy is in the vast majority of cases not serious it does require review when it occurs. Sometimes surgery is necessary but often care is possible without the need for an operation in most people with either a prolapsed or a retracted colostomy.

Jennie Burch