Stoma Prolapse

Pat Black M.Sc, RGN, RCNT, FETC, FPA Cert.
Specialist Nursing Team (Colorectal and Stoma Care)
The Hillingdon Hospital NHS Trust Middlesex

A prolapse of the stoma can be very alarming for the patient and can occur without any apparent reason. Prolapse can be seen more frequently in patients who have temporary loop stomas, either colostomy or ileostomy. A stoma prolapse is when the bowel telescopes out of the skin opening making it longer in length.

A prolapse is not an uncommon complication and can be found alone or in association with a parastomal hernia. When a temporary or loop stoma, either colostomy or ileostomy, is not fixed by sutures there is always the risk of either or both of the loops prolapsing.

Often in a loop stoma, the part of the stoma nearest the back passage (distal segment) is most likely to prolapse.

Common reasons are:

- An excessively large opening in the abdominal wall, which may be the result of surgical technique or an oedematous bowel at the time of construction.
- Inadequate fixation of the bowel to the abdominal wall.
- Poorly developed abdominal muscular support (as in infants).
- Increased abdominal pressure from disease, coughing, sneezing and crying (such as in infants).

Conservative Management

It can be a distressing and frightening situation for the patient to experience a stoma prolapse, which may cause them to rush to the Accident and Emergency department. Reassurance that the condition is not serious is needed and information on how the patient may help him or herself is required.

Conservative management is often the way forward for the patient to manage a prolapsed stoma. Often the prolapse can be reduced by the patient lying down on the bed for about 20 minutes to relax the abdominal muscle and reduce the intra abdominal pressure. Gentle pressure applied continuously against the prolapsed distal loop will aid the bowel to return to the intraperitoneal space. If the prolapsed bowel is swollen a cold compress (ice cubes in a plastic bag wrapped in a towel and applied to the stoma) will reduce the swelling.

When a prolapse is managed conservatively the patient will need frequent supervision by the stoma care nurse and the prolapse and appliance regularly evaluated. Help after the prolapse has been reduced can be obtained in the form of a support belt across the stoma and a specialised plastic stoma cap that is held in place by the belt. Many ostomy product manufacturers now make specialist pouches to help in the management of both herniated and prolapsed stomas.

Surgical Intervention

This is only needed if the blood supply to the prolapsed piece of bowel is compromised or if there is a bowel obstruction associated with the prolapse. Surgical correction consists of cutting away the excess bowel and removing it and re-suturing the stoma to the abdominal wall. Alternatively, the stoma may be re-sited and if previously a loop stoma, an end stoma constructed.

Ongoing care

Because the prolapsed stoma will extend into the pouch and will increase in diameter the mucosa (outside) of the stoma may rub and bleed. This may also cause mechanical trauma and interference with the pouch seal. Two-piece appliances should be used cautiously to prevent the prolapsed stoma becoming pinched between the flange and the appliance when securing.

Editors Comment

If you are experiencing any problems with your stoma such as prolapse always consult your stoma care nurse.

If you have had a prolapse and would like to share your experiences please contact Tidings;
e-mail:
editor@ colostomyassociation.org.uk
or write to:
Colostomy Association
2 London Court East Street
Reading RG1 4 QL