

Random Thoughts and Tips on Urinary Diversions - Urostomy surgery

Last Updated Monday, 23 June 2008

{niftybox width=180px,float=right,textalign=left}

Hospitalisation for cystectomy surgery

External links :

[Cystectomy for men-ileal conduit/urostomy](#)

[Cystectomy for women-ileal conduit/urostomy](#)

Mt. Sinai Hospital - helpful pages:

[Peristomal Skin Complications](#)

[Stoma Complications](#)

[Selecting an Appliance](#)

{/niftybox}

Also on this page: [Stomas](#), [appliances](#), [skin problems](#) and [peri-stomal hernias](#)

By Roni Olsen

Excerpted from; [A Guide to Bladder Cancer, Urostomy and Impotence](#)

It is not essential to have a urinary bladder to sustain life, but it is essential to maintain an uninterrupted flow of urine from the body. Fortunately, this can be accomplished with one of the urinary diversion procedures. The urostomy resulting from this surgery is not the end of life but rather a means of prolonging life, a second chance at life for those whose urinary bladders must be removed. Understanding the critical role of ostomy surgery, however, is essential to both the physical and psychological adjustment to the altered body function and diminished self esteem that routinely accompany most ostomy surgeries. As body strength is regained following radical cystectomy, the physical and mechanical problems of dealing with any ostomy moderate and even become routine, but the psychological adjustment often takes a much longer period of time. Each urostomy patient will, of course, have his/her own set of physical and psychological problems with which to contend. Some will have the support of a caring family and/or friends to help them through the period of adjustment, and others less fortunate may have to fight the uphill battle alone. Whatever the circumstance, each urostomate's attitude is ultimately the key to life with a urinary diversion. Although a urinary diversion definitely alters body function and requires some relatively minor daily maintenance, it need not permanently limit a person's activities, abilities, interests or horizons. The urostomate in tune with life will understand that each day is a very special gift to be treasured and not wasted, exhilarate in the love and laughter of children, family and friends, embrace the climb to the mountain top, rejoice in a journey through minarets at sunset, welcome the new beginning of each spring, and pause to smell the roses along the way.

The three most common types of ostomies are: [colostomies](#), [ileostomies](#) and [urostomies](#). [Urostomies \(urinary diversions\)](#)

are probably the most complicated because they connect directly to a life-supporting system, the kidneys. Additionally, due to the relatively rare demand for radical cystectomy, many urological surgeons have very little experience with creating a urinary diversion and/or and stoma construction. To help minimize problems, the candidate for ostomy surgery should be advised to select a surgeon who is experienced in the particular type of surgery he/she needs. Many factors bear on operating time, procedure options and complications, such as:

The patient's health, weight and age

The condition requiring cystectomy and/or extent of disease

The effect of radiation and/or chemotherapy, and

The experience and dexterity of the surgeon

There are three main types of urinary diversions:

Incontinent

Internal continent reservoirs (pouches) with an abdominal stoma

Internal continent reservoirs that are reconnected to the urethra to provide normal urination.

The incontinent urinary diversion, also known as the Bricker's loop, ileal loop, or ileal conduit, was developed in the 1950s and rapidly became the gold standard for urinary diversion. It is still the most frequently performed urinary diversion, primarily because it is a relatively uncomplicated procedure, and it is also the only urinary diversion procedure most urologists have been trained to perform. Although the majority work reasonably well, the ileal conduit is far from the perfect solution because of the high incidence of ureter and stoma strictures and urinary reflux to the kidneys. These strictures frequently impair, or even block, urine flow, and may require surgical revision. Additionally, the incidence of ascending bacteria and urinary reflux remains substantial and results in repeat kidney infections and progressive kidney deterioration in up to 30% of the cases.

The ileal conduit is made from a 6 to 10 inch long segment of ileum (small intestine) which is separated from the small intestine with its blood and nerve supply, the web-like mesentery, carefully preserved. One end of the conduit is closed with stitches or staples, and the other end is brought to the surface of the abdomen to form a stoma (opening). The ureters are implanted into the closed end of the conduit which serves as a pipeline for a steady flow of urine from the ureters through the abdominal stoma and into an external appliance (bag) attached to the abdomen. Ideally, urine should flow continuously through the stoma at approximately twelve to fifteen drops per minute. A healthy stoma is pink to red in color and also excretes mucus and moisture, both normal excretions of the ileum. Fortunately, the long stringy mucus threads flow easily with urine.

It is not uncommon for people with ileal conduits to have leakage around the appliance faceplate and/or a variety of peristomal skin (skin around the stoma) problems. Urostomates need to be aware that stoma size and shape may change, especially with weight gain or loss or an increase in physical activity, that leaking may occur, and a different type of faceplate and appliance may be required. Although this is particularly common during the first few months after surgery, it can happen at any time. Fortunately, a variety of urinary appliances is available, ranging from a one-piece disposable with a soft, flexible faceplate to a two piece reusable appliance with a semi-rigid or rigid plastic faceplate. If the stoma is flush with the abdomen or located in a body fold, it may be necessary to use an appliance with a semi-rigid convex faceplate and a belt to help make the stoma protrude in order to prevent leakage. Care must be taken to routinely check the appliance fit and make any necessary adjustments. The faceplate opening should fit within 1/8 to 1/16 of an inch around the stoma.

Common peristomal skin problems include yeast and fungus infections, pimples, ulcerations, warty looking, gray, raised encrustations and/or white crystal deposits on the peristomal skin and/or stoma. These conditions require prompt and appropriate treatment by an ET Nurse. Since all ET Nurses do not have equal urostomy experience, however, it may be necessary to seek out another ET if problems persist. Prescription medications may be required for severe skin conditions. Preparations that contain cortisone must be used sparingly because they have the potential to cause skin to become thin and fragile with prolonged use. Urostomates should check with an ET Nurse or physician for specific directions before using any skin products. The Quarterly, UOA newsletters and UOA members are also good sources for tips on dealing with appliance and skin problems.

The two most common causes of skin irritation are chemical and mechanical that are caused by leaky urine and rough treatment of the skin. Chemical irritation results from the exposure of peristomal skin to urine, adhesives, solvents, cleansers, and soap. Since allergic skin reactions are always a possibility, new products should always be tried out on a small area of skin outside of the faceplate. Peristomal skin and stomas that are awash in urine are prime targets for leaks, skin irritations, and crystal buildup around the stoma, especially during the postoperative period when the greatest change in stoma size and shape occurs.

Mechanical irritations are usually caused by improper appliance removal and/or close shaving, which may strip protective layers off of the peristomal skin. To minimize damage, the faceplate should be removed gently by carefully pushing the skin away from the adhesive, instead of pulling the adhesive away from the skin. Also, starting at the top of the faceplate and slowly working toward the bottom reduces tearing and pulling on the skin as well as the hair follicles, which grow in the same downward direction. Vigorous scrubbing or use of abrasive cleansers also damages the skin. Adhesive removers may be used sparingly and gently if necessary. Body hair on the peristomal skin occasionally needs to be carefully shaved or clipped with scissors to further reduce pulling of the hair and skin. An electric razor can be used, but disposable razors are not recommended because they may damage the top layer of skin.

Occasionally, it is necessary to air the peristomal skin. It helps to find a warm, private, comfortable place to sit and read or watch TV, and to place a waterproof pad or a towel underneath. The continually flowing urine can be absorbed with several wicks (made from a paper towel, rolled up like a cigarette and taped in the middle), a cotton filled small mouth bottle that fits around the stoma or a clean folded washcloth carefully positioned under the stoma. A hair dryer set on cool, held at least one foot away from the stoma, will speed drying time. Any urine that gets onto the skin during the airing process should be gently washed off with a clean warm cloth.

Since it is imperative to insure a constant flow of urine away from the stoma, the appliance needs to be connected to a long thin tube that drains into a collection jug at night or when lying down for a few hours. The tube and jug need to be cleaned daily with one of the germicidal solutions. The reusable appliances also need to be cleaned in a similar manner when changed, typically every three to six days. Many people find it is easier to change an appliance in the morning before drinking liquids, and it also helps to bend over a few times to help expel urine from the conduit. A wall mirror and a dissolvable paper guide strip (the ½ inch paper strip fits inside the faceplate opening) make it easier to center the appliance over the stoma. Of course, it is important to always have a backup appliance ready and available at all times.

In the early 1970s, Dr. Nils Kock introduced his innovative Kock continent ileostomy pouch, an internal reservoir for ileostomates who required colon removal. This also opened the door for the development of continent urinary reservoirs. The Kock pouch (Kock continent urinary pouch - pronounced "coke") is made from approximately two feet of ileum. At each end of the pouch an intussuscepted valve (folded back on itself like a turtleneck to prevent leakage and/or reflux) is created. The ureters are connected to the internal valve which prevents reflux to the kidneys, and the end of the other valve is brought to the abdominal surface to form a small continent stoma.

The Kock pouch is emptied by inserting a soft silicone catheter with a coude tip (firm tip) into the stoma 4 to 8 times a day. Catheterization is convenient, easy and painless, and maintenance is minimal. The Indiana pouch and several other varieties, including the Mainz, Miami, Studer, and Mitrofanoff, are also internal continent reservoirs that are catheterized. They are much simpler to construct than the Kock pouch, however, and they also hold a smaller volume of urine. All of these continent pouches have a moist stoma that needs to be covered by a small waterproof pad to protect clothing. A third of a Maxi-Thin pad, held in place with two small pieces of micropore tape, works quite well as a stoma cover.

Although catheterization is not a sterile procedure, the catheters should be rinsed and cleaned with a germicidal solution after each use. Again, it is wise to check with an ET Nurse for directions. UOA's Continent Diversion Network is also a good source of support and information: www.ostomyalternative.org or 1-800-456-7494. Catheters fit easily into a small plastic ziploc bag, as well as a pocket, purse, backpack, or glove compartment and should always be available.

For men and women who meet special criteria, the T-pouch (similar to the Kock pouch), and the neobladder (Studer and variations) can be reconnected to the urethra to provide normal urination. These reconnects require a lot of patience and retraining of muscles to control urine flow, and some individuals never achieve 100% continence. The majority find continence is easily maintained during the daytime, but may need to wear a pad as a safety measure. Nighttime incontinence, however, remains a problem for many. Some people wear Depends, some get up a few times during the night, and some men use a penile sheath with a tube connected to a collection jug.

In most cases, radical cystectomy renders the male impotent, an understandably frightening and psychologically intimidating prospect for even the most stoic individual to contemplate. In appropriate cases, however, a nerve-sparing technique can be used to maintain erectile function. Once again, the skill and experience of the surgeon is critical. Over the past two decades, medicine and engineering have combined to develop a variety of penile prostheses which provide acceptable alternatives to impotence. The three-piece inflatable prostheses are the most comfortable, unobtrusive and satisfactory. As a result, sexual rehabilitation for men is an integral part of treatment for radical cystectomy, an important step that plays a major role in restoring both self-image and an acceptable quality of life to the male urostomate. Although none of the prostheses provide an exact duplication of a natural erection, the penile implants are sufficiently similar to allow the patient to resume sexual activity close to what he enjoyed prior to the surgery. Also, since 1982, the use of vasodilatory drugs, PEP, the pharmacological erection program, or penile injection has produced satisfactory results for a large number of men and their partners.

See also: [Impotence, Penile Prostheses and Alternatives](#)

Female urostomates frequently require extensive ablative surgery, and they may require reconstructive pelvic surgery to remain sexually active.

Approximately 700,000 Americans and countless thousands of people around the world are alive today because they have had ostomy surgery. In the majority of cases, ostomy surgery is performed as a life-saving alternative to a life-threatening physical condition. Nonetheless, most new ostomates find life with an ostomy overwhelmingly unpleasant for the first few months. Even those individuals who have had the advantage of specialized care before, during and after surgery will most likely have to work their way through a difficult period before they finally adjust to their ostomies. With few exceptions, an ostomy is viewed as an unnatural and very offensive alternative to the natural process of physical elimination. This is a perfectly normal response that typically requires a period of adjustment. Once health and strength

are regained and the ostomy is under control, however, there is no good reason to dwell on the misfortune of diversionary surgery. Ostomates are not only able to do anything they have ever done, but the majority take on tasks and adventures they had not even thought of prior to ostomy surgery.

Roni and Ben Olsen joined the UOA Metro Denver Chapter in 1982. These quotes are from Roni's book, A Guide to Bladder Cancer, Urostomy and Impotence. For more info, see 'recommended reading

See also: [Internal Pouches Ostomy Resources](#)

[back to cystectomy](#)

[back to invasive bladder cancer Stomas and Ileal Conduits](#)

Roni Olsen

[Resources-where to find ostomy appliances, etc.](#)

[Info on peri-stomal hernias, below](#)

[Q & A and miscellaneous info](#)

Thousands of urostomates live full, active and happy lives with ileal conduits - also called Bricker's loop and ileal loop - and external appliances.

The ileal conduit requires an external appliance (also called a pouch or bag) to collect urine as it dribbles out of the abdominal stoma. The size, shape and location of the stoma need to be considered when selecting an appliance. It is not unusual to have to try a few different appliances before finding a reliable, leak-resistant and comfortable appliance. An ET Nurse (also called an Enterostomal Therapy Nurse or Ostomy/Wound Nurse) with a LOT of experience with urinary stomas can be very helpful (see below).

Urinary reflux to the kidneys, kidney infections and ureter strictures are not uncommon with ileal conduits. To help keep the kidneys properly flushed, urostomates should drink 8 to 10 glasses of water daily, more if very active, fever and/or sweating. Any flank/back pain, fever, unusually strong smelling or dark urine, or reduction in urine output should be reported to the urologist ASAP.

Stomas:

Q. Are all stomas alike?

A. No, stomas are as individual as snowflakes.

A healthy stoma is pink to red in color and secretes normal intestinal fluid and mucus along with urine. The new stoma is sutured to a round opening on the abdomen. It stays puffy and swollen for several days and requires an appliance with a faceplate opening large enough to accommodate the post-op swelling. An appliance with a smaller faceplate opening may be needed as the stoma and surrounding tissue heal and the swelling goes down. Ideally, the stoma should be located below the waistline on a flat part of the abdomen (usually the right side), slightly raised above the skin, and away from deep body folds, scars, bony prominences, or other problem areas.

Stomas may change shape and size at any time, but most changes take place within the first 6 months after surgery. The stoma should be checked and measured weekly for 6 weeks after surgery, and monthly for several months unless a problem occurs earlier. Stomas may also change with normal body movement; the stoma that is round when standing may become oval when changed to a sitting position. Stoma measuring guides are available with ostomy supplies, so the ostomate can do his/her own measuring if necessary.

Stomas come in all shapes and sizes, each with its own unique appliance requirements. The ideal stoma should be 5/8 to 3/4 inch in diameter and protrude 1/16 to 1/8" from a flat part of the abdomen. This allows the stoma to actually protrude far enough into the center opening of the appliance faceplate to help prevent urine from puddling on the peristomal skin, the skin around the stoma. The faceplate opening should fit 1/16 to 1/8 inch around the stoma. Urinary stomas that are flush with the skin or located in a problem area usually allow urine to seep under the faceplate (urine can seep through a pinhole). These stomas make it difficult to find a good, reliable leak-proof appliance.

Stomas have no feeling but need to be handled gently. They may be uncovered during showering or bathing, but NOT scrubbed - only patted gently with a soft towel. When bumped or rubbed, some of the tiny capillaries in the highly vascular stoma may bleed slightly. If bleeding is substantial or persists for several hours, a physician or ET Nurse should be contacted. Any noticeable change in color or general appearance, encrustation or bumpiness also requires medical attention without delay.

Appliances:

Q. Are all appliances the same for all ostomies (urostomy, ileostomy, colostomy)?

A. No, a variety of appliances are made for urinary ostomies. Some bags have an internal anti-reflux valve, some do not. It is best to use a bag that does to help reduce urinary reflux from the bag to the stoma.

Q. Can all urostomates wear all types of urinary appliances?

A. No, each urostomate requires an appliance that works with his/her stoma. This usually takes a bit of trial and error along with a few four letter words.

Urinary appliances are available in one piece and two piece units, some disposable, others reusable. They have a bag (external pouch) to collect urine. The bag is attached to a faceplate to hold it in place on the abdomen. Most appliances are designed to be used as a complete unit, but some mixing and matching of products manufactured by different

companies is possible. Faceplates are made in a variety of materials from soft thin and flexible wafers to thick and rigid plastic disks. They are available in several different thicknesses and convexities to accommodate problem stomas: flush with the skin, retracted, or located in hard to fit areas. A few companies will make custom faceplates based on a mold submitted by the urostomate who has an odd shaped stoma or a stoma located in a difficult spot.

Disposable appliances are sanitary, easy to apply and can be tossed into the trash. They have round or square, soft, pliable faceplates with a waterproof backing to adhere to the skin, and they conform to body shape and movement. They are usually only suitable for protruding stomas on a flat, smooth and firm abdomen because any wrinkles, folds or creases on the abdomen create similar irregularities in the skin-like faceplates that quickly develop into channels for urine. Two piece disposable appliances have a separate bag and faceplate which have to be put together to make a complete appliance. Most of these faceplates have a raised rim around the center opening that is designed so the bag can be easily snapped on or off while the faceplate stays in place. This makes frequent bag changes easy, eliminates unnecessary wear and tear on the peristomal skin and eliminates pouch cleaning.

Most reusable appliances are two piece systems, made up of a bag and a semi-rigid or rigid faceplate. Faceplates are made of rubber, soft plastic or nylon, and they are either elliptical or round. They do not conform to body shape or movement and are somewhat uncomfortable as they help hold the area around the stoma flat enough to prevent folds or wrinkles from forming under the faceplate. Either a two sided waterproof adhesive disk or a contact skin adhesive is applied to the faceplate to hold it in place on the abdomen. They also need a small narrow belt to help hold them in place. The bag has to be stretched over a raised rim around the center opening of the faceplate. This requires good manual dexterity, a consideration for the ostomate with physical or visual impairment.

Vance Products makes a one piece reusable appliance, the VPI. It does not have a faceplate. The apron-shaped appliance has an integral small soft silicone O-ring that fits around the stoma and does not require any adhesive. The VPI only works with protruding stomas and is held in place with a narrow belt.

Leaking & cleaning

Q. Are leaking problems uncommon?

A. No, most urostomates have to try a few different appliances before finding one that is reliable and can be worn safely for 3 - 6 days.

Those who have difficulty finding a reliable appliance need to find an ET Nurse who knows how to deal with ileal conduit problems. It may be necessary to stand on someone's feet and holler until you get to the right person. Once the right appliance is found, the urostomate can and should lead a full, active, normal life.

The bag needs to be emptied every 1 ½ to 2 hours, and it is critical to keep urine flowing away from the stoma at all times and to keep it from back-puddling around the stoma. Shortly after urine collects in the bag, it becomes contaminated with bacteria. Back-puddling allows bacteria from the pouch access to the stoma, the ileal conduit and eventually the kidneys. The urine also undermines the adhesive on the faceplate and creates channels for leaking. When emptying is not convenient, leg bags can be used for extra capacity. It is also important to connect to a night drain when lying down for more than a few hours.

Appliances, night drains, leg bags, tubing need to be cleaned with a germicidal solution. Several products are available at the medical supply stores.

Peristomal skin problems

Q. Are skin problems all alike? Are they uncommon?

A. No, skin problems are varied and regrettably, very common.

Peristomal skin problems range from small red pimples to grayish encrustation on the stoma to weeping sores, and they should never be ignored. Continuous urine on the skin, skin preps, soaps, cleansers, adhesives, solvents, allergic reactions, shaving, and pulling on the peristomal skin can cause problems. The motto, "less is best," applies when dealing with skin preparation and appliances. Appliances should be removed by carefully and gently pulling downward away from the skin. Hair removal should be limited to light, careful use of an electric razor or clipping with scissors. Treatment for skin problems ranges from vinegar/water soaks to prescription ointments or sprays. See an ET Nurse and other ostomates for help.

Miscellaneous Hints & Tips

Symptoms of kidney infection include chills, fever, flank and/or back pain, unusual urinary output, change in the amount of mucus or urine (cloudy and/or dark).

Culture urine from the stoma (urine in the bag is contaminated with bacteria) to determine which bacteria is present). Some bacteria require specific oral antibiotics, some need specific IV antibiotics.

Always try new products or adhesives on a patch of skin away from the peristomal skin. A lot of people are allergic to latex.

To help heal peristomal skin problems - wash and air dry. Use a clean washcloth or a small mouthed bottle filled with cotton to catch urine as it dribbles out of the stoma. It is also ok to use a hair dryer set on low to dry the skin.

Fold and roll up a paper towel like a cigarette. Tape around the middle. Both ends can be used to "wick" urine while changing appliances.

Keep a spare appliance ready at all times, even at home.

Water-soluble guidestrips are available. They can be put inside faceplate opening to help center the appliance on the stoma.

If it's difficult to see the stoma, a mirror on the wall can be helpful to centering the faceplate on the stoma.

Keep all appliance equipment in a clean drawer or box.

A variety of pouch covers are available through suppliers. They can also be made from handiwipes, T-shirts or many other materials.

Wide belts (about 4" wide) can be used for strenuous activity. They have an opening to accommodate the appliance.

Night drain - The closed Foley catheter night drain used in the hospital is not recommended for long-term use because they are impossible to clean and are rather quickly contaminated with bacteria. Put the night drain in a wastebasket or bucket. A brick or stone in the bucket will help keep it from tipping over.

Use two mattress pads over a waterproof sheet - won't be as hot or as noisy.

PH strips at pharmacy to check acidity of urine.

Cranberry Juice, cranberry pills and Vitamin C help keep urine acidic.

In the US: Contact UOA (United Ostomy Association) 1-800-826-0826 for the UOA chapter in your area. They can also supply information on the International UOA.

How to find an ET or Ostomy Wound Nurse

Finding an ET or Ostomy/Wound Nurse with good urinary diversion experience may take some effort. Check the website -

<http://www.wocn.org> . Click on Services and resources, click on referrals, then click on consultant registry for a list of names. Or, email the executive director, Maria Garces at - maria@wocn.org. The National office is in Laguna Beach, CA - 1-888-224-WOCN.

Also, check with the American Cancer Society for a list of Comprehensive Cancer Centers. Contact the Department of Urology at one of the centers and ask for the ET or Ostomy/Wound Nurse.

Check with the United Ostomy Association for names of ET Nurses and for members with urostomies. Local UOA chapters will have the names of ET Nurses in their communities. Many fellow ostomates can be contacted through the United Ostomy Association, a good volunteer support group with almost 500 chapters in the US. National UOA at 1-800-826-0826 can supply the name and number for all chapters.

Another place to find support is through the WebCafe's affiliated email list/support group for bladder cancer warriors, see: [listinfo.asp](#)

For more detailed information see "A Guide to Bladder Cancer, Urostomy and Impotence," by Roni Olsen and "Urinary Ostomies - A Guidebook for Patients," by Katherine Jeter, RNET.

Complications: Peristomal hernias

For the vast majority of patients, the only symptoms of the presence of the hernia is the bulge around the stoma. For most patients this is hardly noticeable and causes no significant problems with bowel function or the care of the ostomy. Over time, however, this bulge may gradually enlarge, as the defect in the abdominal muscle becomes larger.

The increase in the size of the hernia is thought to be due to intermittent increases in intrabdominal pressure from any coughing, lifting or straining. The larger the defect, the greater the potential for more loops of bowel to enter the hernia sac. A larger hernia can begin to cause problems with keeping a good seal on the stoma appliance. Changes in the contour of the skin around the stoma may necessitate a change in the type of appliance worn or the addition of a stomal belt to keep the appliance secure.

Continued problems with the stoma appliance due to the bulge are the most common indication for repair of the hernia. Although in most patients the hernias are asymptomatic, in a few they may cause abdominal pain or intestinal obstruction. The vast majority of patients who develop peristomal hernias learn to live with them, as they cause little or no problem. However, for those who are having substantial difficulties with the stoma due to the bulge or have developed pain or episodes of obstruction due to the hernia, an operation to repair the hernia is available. Unfortunately, this is no small undertaking.

There are a variety of methods and techniques to attempt to repair these hernias. The simplest method is to make an

incision in the vicinity of the stoma, push the contents of the hernia sac back into the abdomen and close the muscle layer with some stitches. Unfortunately, this simple technique has a very high rate of recurrence of the hernia and is rarely utilized because of the long-term failure rate. Another "local repair" is to make a similar incision around the stoma and place a piece of synthetic mesh to close the defect. This technique has a lower recurrence rate but has a greater rate of wound problems.

The mesh products that are now available have revolutionized the ability of surgeons to repair many types of hernias. However, placement of this type of "foreign body" always places the patient at some risk of infection. Utilizing mesh around a stoma is always somewhat worrisome due to the higher risk of contamination of the mesh with bacteria from the stoma at the time of its insertion. A further concern is the possibility of placing the mesh too tightly around the bowel as it exits the abdomen. If it is placed too tightly, it may inhibit the emptying of the bowel content through the stoma postoperatively. Also, if it lies up against the mesh it may, with time, slowly erode into the bowel wall, necessitating removal of the mesh. Alternatively, placing the mesh too loosely may result in not closing the entire hernia defect around the stoma and allow another hernia to occur.

Many peristomal hernia repairs require that the abdomen be reopened, usually through the same incision that was used to create the original stoma. From inside the abdomen, a piece of mesh can be place around the stoma to repair the hernia. This still carries all the possible risks of mesh placement. However, the risk of contaminating the mesh with bacteria from the stoma is felt to be less and the ability to better judge mesh position make this a better option than the local repairs.

Lastly, in some cases it is necessary to completely take down the stoma, repair the abdominal wall and create a new stoma in an entirely different location. This is most often the preferred option if there are other problems with the original ostomy, such as a poor location, narrowing of the stoma opening or retraction of the stoma below the skin level. In these situations, the patient is far better off with a completely new ostomy than trying to salvage a stoma that was giving the patient problems even before the development of the hernia. In summary, repairing a peristomal hernia is certainly possible to accomplish, but often requires a major abdominal surgery with all its attendant possible complications. Therefore, we do not recommend that every peristomal bulge be repaired. Rather, if adjustments to the stoma appliance can be made such that a reliable seal can be maintained and the hernia remains asymptomatic, there is no need for surgery. incision made directly around the stoma. Source:

<http://www.wramc.amedd.army.mil/providerinfo/enterostomal/10.htm>