The precise name of the ostomy depends on the location of the stoma. An ileostomy is an ostomy made in the ileum of the small intestine. In an ileostomy, the colon, rectum, and anus are usually completely removed (total proctocolectomy with permanent ileostomy). The anal canal is closed, and the end of the terminal ileum is brought to the body surface through the right abdominal wall to form the stoma. A temporary or loop ileostomy may be formed to eliminate feces and allow tissue healing for 2 to 3 months following an IPAA. A loop of ileum is brought to the body surface to form a stoma and allow stool drainage into an external pouch. When the ileostomy is no longer necessary, a second surgery is performed to close the stoma and repair the bowel, restoring fecal elimination through the anus.

In a continent (or Kock’s) ileostomy, an intra-abdominal reservoir is constructed and a nipple valve formed (the ileum folded back on itself) from the terminal ileum, before it is brought to the surface of the abdominal wall (Figure 24–8). Stool collects in the internal pouch; the nipple valve prevents it from leaking through the stoma. A catheter is inserted into the pouch to drain the stool.

Nursing care of the client with an ileostomy is outlined on below and on the following page. Procedure 24–1 on page 657 describes how to apply one- and two-piece drainable ostomy pouches.

**NURSING CARE OF THE CLIENT HAVING AN ILEOSTOMY**

**PREOPERATIVE CARE**

- Provide routine preoperative care and teaching as outlined in Chapter 7.
- Refer to an enterostomal therapist for marking and teaching about the stoma location, ostomy care, and options for ostomy appliances. It is important to begin teaching prior to surgery to facilitate learning and acceptance of the ostomy postoperatively.
- Discuss the availability of a local United Ostomy Association chapter, and provide a referral as necessary or desired. Local chapters often have members with stomas who are willing to provide both preoperative and postoperative teaching, listening, and support.
- Provide preoperative bowel preparation as ordered. Cathartics, enemas, and preoperative antibiotics are often ordered to reduce the risk of abdominal contamination and infection after surgery.

**POSTOPERATIVE CARE**

- Provide routine postoperative care and teaching as outlined in Chapter 7.
- Apply an ostomy pouch over the stoma. (See Procedure 24–1.) Stool from an ileostomy is expressed continuously or irregularly, and it is liquid in nature; continuous use of a pouch to collect the drainage is therefore necessary.
- Assess frequently for bleeding, stoma viability, and function. In the early postoperative period, small amounts of blood in the pouch are expected. A healthy stoma appears pink or red and moist as a result of mucus production (Figure 24–7). It should protrude approximately 2 cm from the abdominal wall. Frequent assessment is particularly important in the initial postoperative period to ensure stoma health and monitor for possible complications. A dusky, brown, black, or white stoma indicates circulatory compromise. Other possible stoma complications include retraction (indentation or loss of the external portion of the stoma) or prolapse (outward telescoping of the stoma, that is, an abnormally long stoma).
- As the stoma starts to function, empty the pouch, explaining the procedure to the client. Initial drainage is dark green, viscid, and usually odorless. Drainage gradually thickens and becomes yellow-brown. Empty the pouch when it is one-third full. Measure drainage, and include it as output on intake and output records. Rinse the pouch and reapply the clamp. Emptying the pouch when it is no more than one-third full helps prevent the skin seal from breaking as a result of the weight of the pouch. Because of the potential for excess fluid loss through ileostomy drainage, it is important to include it as fluid output.

(continued)
UNIT VI / Responses to Altered Bowel Elimination

NURSING CARE OF THE CLIENT HAVING AN ILEOSTOMY (continued)

- Assess the peristomal skin. Skin around the stoma should remain clean and pink and free of irritation, rashes, inflammation, or excoriation. Skin complications may arise from appliance irritation or hypersensitivity, excoriation from a leaking appliance, or Candida albicans, a yeast infection.
- Protect peristomal skin from enzymes and bile salts in the ileostomy effluent. Using a skin barrier on the pouch is essential. Change the pouch if leakage occurs or if the client complains of burning or itching skin. Enzymes and bile salts normally reabsorbed in the large intestine are irritating to the skin. Excoriation of skin surrounding the stoma impairs the first line of defense against microorganisms and can interfere with the ability to achieve a tight skin seal and prevent pouch leakage.
- Report the following abnormal assessment findings to the physician:
  a. Allergic or contact dermatitis. A rash may result from contact with fecal drainage or indicate sensitivity to pouch, paste, tape, or sealant.
  b. Purulent ulcerated areas surrounding the stoma. Disruption of the protective barrier of the skin allows bacterial entry.
  c. A red, bumpy, itchy rash or white-coated area. This is a manifestation of Candida albicans, a yeast infection.
  d. Bulging around the stoma. This finding may indicate herniation, caused by loops of intestine protruding through the abdominal wall.
- Apply protective ointments to the perirectal area of clients with newly functioning ileoanal reservoirs and anastomoses. This helps protect the skin from the initial stools. As stools thicken and become fewer per day, the client experiences less perirectal irritation.

CLIENT AND FAMILY TEACHING

- While caring for the ostomy, explain procedures to the client. Teaching is immediate and ongoing to facilitate acceptance of the ostomy and self-care.
- Teach to manage the pouch clamp, to empty, rinse, and peristomal skin changes. Self-care is vital to independence and self-esteem.
- Instruct now to use an electric razor to shave the peristomal hair if necessary. An electric razor prevents accidental cutting of the stoma with a razor blade.
- Teach to check the stoma and peristomal skin with each pouch change. Ongoing assessment is important for optimal health and function of the stoma and surrounding skin. Stripping of tape or excessively frequent pouch removal may cause mechanical trauma to peristomal skin. Chronic skin irritation by ileostomy effluent may lead to pseudoverrucous lesions, or wartlike nodules.
- Instruct to report abnormal appearance of the stoma or surrounding skin (as noted previously and below) to the physician:
  a. Narrowing of the stoma lumen. This indicates stenosis and may interfere with fecal elimination.
  b. Lacerations or cuts in the stoma. The stoma contains no nerves, so trauma may occur without pain.
  c. Separation of the stoma from the abdominal surface. This potential complication may require surgical repair.
- Emphasize the importance of adequate fluid and salt intake; the risk for dehydration and hyponatremia is increased particularly during hot weather, when fluid is lost through perspiration as well as ileostomy drainage. Water intake should be sufficient to maintain pale urine and an output of at least 1 quart per day. When exercising in hot weather, the client should consume extra water and salt. High-potassium foods, such as bananas and oranges, may also be recommended. Loss of the reabsorptive surface of the large bowel increases the amount of water and sodium loss in the stool. If the ileostomy is high (more proximal in the ileum), additional potassium losses may also occur.
- Discuss signs and symptoms of fluid and electrolyte imbalances:
  a. Extreme thirst
  b. Dry skin and oral mucous membrane
  c. Decreased urine output
  d. Weakness, fatigue
  e. Muscle cramps
  f. Abdominal cramps, nausea, vomiting
  g. Shortness of breath
  h. Orthostatic hypotension (feeling faint when suddenly changing positions)
- Discuss dietary concerns. A low-residue diet is recommended initially (see Table 24–8). Foods that may cause excessive odor or gas are typically avoided as well. Because food blockage is a potential problem, high-fiber foods are limited, and foods that may cause blockage, such as popcorn, corn, nuts, cucumbers, celery, fresh tomatoes, figs, strawberries, blackberries, and caraway seeds are avoided. Symptoms of food blockage include abdominal cramping, swelling of the stoma, and absence of ileostomy output for over 4 to 6 hours.
- Teach self-care measures to relieve food blockage:
  a. Take a warm shower or tub bath. This can help relax the abdominal muscles.
  c. Drink warm fluids or grape juice if not vomiting. This provides a mild cathartic effect.
  d. Massage peristomal area. Massage may stimulate peristalsis and fecal elimination.
  e. Remove pouch if the stoma is swollen, and apply a pouch with a larger opening. If the stoma swells, the pouch may create a mechanical obstruction to output.
- Notify the physician or enterostomal therapy nurse if:
  a. The above measures fail to relieve the obstruction.
  b. Signs of a partial obstruction persist including high-volume odoriferous fluid output, abdominal cramps, nausea, and vomiting.
  c. There is no ileostomy output for 4 to 6 hours.
  d. Signs of fluid and electrolyte imbalance occur, such as weakness, dizziness, lightheadedness, or headache. Should self-care measures not succeed in breaking up a blockage, ileostomy lavage, as described in Procedure 24–2 may be required.