

Stoma care is our affair for the senior citizens everywhere

MARGARET COYLE and MARGARET DIXON
Stomatherapists, Addington Hospital

SUMMARY

'n Oorsig word gegee oor stomaterapie met spesifieke verwysing na die bejaarde ostomaat.

Aspekte soos algemene chirurgiese probleme, verlengde hospitalisasie, die behoefte aan opvolg, hantering van hulpmiddels, dieet, verhoudings en vakansies word bespreek. Personeel moet positief wees dat die pasiënt kan en sal leer om sy nuwe situasie te hanteer.

THE HISTORY OF STOMATHERAPY

The first reported colostomy was in 1776 and it was a caecostomy, or opening into the caecum. This was the first attempt to surgically help the problem of an imperforate anus.

The first stomatherapist was a patient in the Cleveland Clinic, Ohio, U.S.A. Now there are 22 countries in the world with qualified stomatherapists. Stomatherapy was founded in South Africa in 1958 and in England in 1967.

The Southern African Stomatherapy Association (SASA) was formed in November 1978 — the last biennial congress was in February 1982. SASA is recognised by the South African Nursing Association. At present the only training school for stomatherapists in South Africa is at Groote Schuur Hospital, Cape Town. The training consists of a six weeks intensive course in anatomy, physiology and practical stomatherapy application.

This article won third prize in the 1982 Curationis-Johnson and Johnson writing competition. The topic of the competition was *Nursing the Aged*

WHAT ARE A STOMA AND STOMATHERAPY?

The word stoma originates from the Greek word meaning mouth. It is usually an artificial opening onto the skin from any part of the alimentary tract or urinary system.

Stomas are either done for faecal diversion, urinary diversion, or fistulae in various forms.

Stomatherapy is the specialist nursing care given to patients with a stoma or ostomy — relating especially to physical, psychological, sexual and dietary education.

This includes pre-operative counselling and a thorough follow-up in every aspect, ensuring continual communication and on-going support.

CAUSES OF STOMAS IN THE AGED

The causes of stomas in the aged are as follows:

Large Bowel

- acute intestinal obstruction
- diverticulitis (inflammation of the diverticulae in the large bowel, especially the sigmoid colon)
- volvulus (a twisted loop of bowel)
- cancer of either the large or small bowel
- rectal prolapse which is impossible to correct surgically
- injuries or abnormalities of the spinal cord

Small Bowel

- ulcerative colitis (inflammatory non-specific disease with a high risk of cancer in later years)
- Crohn's disease (chronic granulomatous inflammatory conditions which occur anywhere in the gastro-intestinal tract)

- familial polyposis coli (a pre-malignant condition with polypi)
- fulminating amoebiasis (which causes dysentery and therefore toxic mega colon)

Urinary

- congenital (neurogenic such as ectopia vesica)
- neoplastic (cancer of the bladder or other pelvic neoplasms involving the bladder such as uterine cancer)
- traumatic (neurogenic bladder due to a fractured spine, an unmanageable urethral stricture or urinary incontinence)

PRE-AND POST OPERATIVE COUNSELLING

Patients are people who come from various social, cultural and religious backgrounds and have been conditioned since childhood to accept certain beliefs, ways of living and attitudes, which produce a unique blend in each individual. Awareness of the ostomate's social and psychological make-up, help the nurses and others involved in the rehabilitation of the stoma patient to give the best support.

Counselling the patient pre-operatively includes an explanation of the type of surgery expected to be undertaken and marking the site on the abdomen where the stoma will hopefully be constructed. The appliances (bags) are shown to the patient and, where possible, another ostomate is introduced to the persons awaiting surgery to help allay their fears and to provide encouragement and reassurance. Many questions are asked and answered to help prepare the new ostomate.

After the operation there is usually a mild state of shock and

only time can help the patient adjust. At this stage loving care is needed. Not all the advice is absorbed by the patient, so simple and basic explanations help to alleviate any emotional upsets and other worrying factors.

The faecal output and consistency improves once the ostomate is well on the road to recovery.

There are stigmas attached to *people wearing collecting bags*. The patient may well have to adapt his body image, that is the mental picture each individual has of his own body. Continuous support from the ostomate's partner and family enables him to accept his new way of life and teaches him to cope in his environment.

PROBLEMS FACING THE AGED OSTOMATE

Delay in presentation

The elderly are often constipated, and have been for years, so when this leads to bleeding piles they are unaware of or do not notice any real change in their bowel habits or take note of any blood in the stool which would indicate the presence of cancer.

Women often have frequent vaginal discharges and a change in bleeding is more often than not ignored — this leads to them not noticing any changes in body functions and therefore delaying early diagnosis.

The general practitioner is overworked, and often unaware of readily available diagnostic aids. The patient to doctor ratio, especially in the rural areas, is in excess.

After surgery the general practitioner should have a referral letter with all details concerning the surgery and equipment so that he can become part of the team providing the follow-up care.

Elderly patients have bowel and urinary fixations. They abuse the use of aperients, using excessive, strong aperients for years to such an extent that they become familiar with almost continuous diarrhoea.

General surgical problems

General nutrition is often poor. However, obesity may be present in the aged which makes siting rather difficult.

Due to slacker muscles as the years go by the chances of peristomal hernias become higher. As a result of herniations there may be difficulty in application of bags and

leakages become more likely.

The elderly also often experience poor healing of perineal wounds and general sensitivity for months, even up to a year. They should be advised to use cushions or air-rings.

Adequate orientation beforehand is important, although the elderly may have poor memory of the pre-operative period. Often the ostomate listens and hears what he wants to, there is thus a need for repeated patient teaching and training after surgery.

Prolonged hospitalisation

The general stay in hospital is longer for the elderly, or more complicated as their standard of health and hygiene is often poor. They are generally slow healers, which can be due to poor nutrition over years.

Initial mobilisation is usually slow and therefore the elderly run a high risk of bedsores and other complications. They often have many other aggravating combinations of illnesses such as hypertension, arthritis and gout. The drugs given for these illnesses can and do have various effects on the elderly ostomate's bowel pattern.

The elderly can easily become reliant on the hospital care givers. The care givers are kind, understanding and supportive. Close friends and family can be over protective in not allowing the elderly patient his freedom and slow but sure gain of confidence. They need to be independent in their own way and not dependent on relatives.

The need for follow ups

The elderly, like all other age groups of ostomates, need continual support and care. Assurance that all is going according to plan is vital. The patient needs reassurance and any minor misunderstandings in treatment or management of ostomy equipment must be ironed out.

The elderly patients are forgetful and may lose and/or muddle their out-patient department cards. This can lead to hasty remarks by hospital staff and no thorough follow-up system.

It would be most desirable to have a district nursing service in all areas. This enables a thorough follow-up and often personal and other problems which are not apparent in hospital become evident only on a visit by a stomatherapy district sister.

Coping with rectal discharge

Rectal discharge is due to mucus from the bowel and part of the normal function of the large bowel. In the women it may be upsetting to have to revert to using sanitary towels. Men find it difficult to get used to the discharge, to them is it degrading, and the expense incurred with the purchasing of sanitary towels may also be a problem. Phantom feelings, that is the urge and wish to pass faeces, are also found.

Appliance management

Simple and effective equipment is required and the correct type of bag must be selected for each patient. It is important to establish a correct routine early on in the recovery period.

The importance of the care of the skin surrounding the stoma must be stressed. The skin must be kept in top condition. Allergies to certain tapes or bags can occur and must be treated promptly.

The patient also needs to be able to cope with the ostomy and to adjust the diet according to output, that is whether he is constipated or has diarrhoea.

An efficient night drainage system must be established for the urostomy patient, enabling an undisturbed sleep.

Issuing of supplies

If the colostomist is to be away for some time he should always take enough equipment along or get a prescription for further equipment from his qualified stomatherapist before leaving the regular source. There is also a detailed national and international list of stomatherapists.

An understandable fear among ostomates is to have enough equipment and hoarding occurs often and easily. The cost of equipment can be quite high and the elderly want to pay at least something towards the cost, if not all.

A box of about 30 average drainable bags costs approximately R40. These bags should be worn for at least 3-4 days and not more than 6-7 days.

Disposal of bags

The bag is emptied, folded and put into a small paper or plastic bag and sealed. The bag is then disposed of

in a waste-bin, litter bin or sani-bin. It is recommended to dispose of bags and dressings daily and not to hoard and then try and dispose of the equipment.

The motion or efflux may be emptied in the lavatory but the bags must not be washed down the toilet as this blocks the plumbing system.

Continual bag change syndrome

A reassuring and good guiding manner will enable the patient to realise that the bags are **only** clean initially when applied and also that the increased cost involved in using extra bags is unnecessary. With continual changing of bag the likelihood of developing sore skin due to mechanical removal is increased.

Diet

Regarding diet there are various schools of thought as there is in the choice of appliances. Basically the ostomate must exercise a degree of discipline over food intake so that eventually the effluent is formed and odourless. Patients soon realise that with a little exercised discipline they will achieve this result, and they will not find themselves having to cope with soiled bed linen and clothes, and offensive odours and gasses.

Disciplined eating does not mean restricting foods but establishing a regime to obtain a natural and full intake of acceptable foods to suit the individual's body so that it is nurtured and healthy. Various drinks and food stuffs need to be tried and tested by the ostomate. Bulklers regulate a motion by natural means, they are not drugs which form bulk. Bran or Metamusil must be taken before eating food and not with too much water.

To avoid undue gas or flatus, food needs to be well chewed with the mouth shut. Little or no talking prevents the drawing in of extra air. Well fitting dentures aid mastication. It is not necessary to eat pureed foods.

It is essential to make sure that the elderly ostomate realises that if he eats correctly he will have the correct output. Gaseous foods are peas, beans, cabbage, onions, cauliflower and aerated drinks. Foods which enhance a loose stool are chocolate and chocolate drinks, orange, fruit juices, cream, avocado pears and fresh fruits.

General anatomy and physiology and the basics of how the gastro in-

testinal track functions is explained to the ostomate by the stomatherapist in simple terms so that he understands how food stuffs are processed and eliminated by the body.

Odour

It is perfectly natural to have an odour from faeces. It must be stressed that all faeces has an odour, but it should not be in excess. Most modern appliances are completely odour proof if applied correctly. Deodorants such as drops, spray or charcoal fillers either attached or incorporated in the bags, can be used to help eliminate odours. Some foods are more odoriferous and flatus producing and it is recommended to cut down on those foods which create an odour problem.

Irrigations

Irrigations should only be offered to those with no known presence of cancer in the past five years. This method is of great help when there have been numerous problems with odour and flatus and the normal routines have not succeeded.

Clothing

Patients must be reassured that they can dress *normally*. In the elderly the abdominal muscles become slacker and supportive girdles and tights can still help ostomates feel the firm support that they were used to prior to surgery. All that is needed is for a hole to be cut in the *pantie girdle* where the stoma is situated.

Bag covers can be worn over the bag to enhance their appearance and also to prevent sweating caused by the plastic against the skin in hot humid weather. Bag covers can be made of flesh coloured soft fabrics.

Baths and showers

There is no reason why a patient cannot bath or shower daily. The patient can bath once the wound is healed and the surgeon has given permission and the patient feels confident. Personal hygiene must be encouraged as it helps to enhance the body image.

Baths can be taken with a bag on or off the body. Water cannot enter the stoma and all appliances are completely air and water tight if applied correctly. Toilet paper can always be kept at hand in case of an

emergency. If the patient is unable to climb in and out of a bath, or to sit in a bath (post-operatively, for example after an abdominal perineal resection) a shower will be equally relaxing, stimulating and refreshing.

Finance

Money and bills, the cost of transport, hospitalisation and medical fees all are a concern to the aged who more often than not have to live off very small pensions — if any at times! Relying on family and friends for lifts and so on removes their very valuable right of independence.

The aged are often unaware and too proud to approach available social welfare resources.

Relationships

When considering personal and sexual relationships of ostomates, it must be realised that each and every partnership in the elderly is unique. Special counselling by the stomatherapist can help alleviate any problems encountered by mutilative surgery.

Orientation and introduction of the family as soon as possible to stomas, surgery, reasons for and basic post-operative care is vital. Rehabilitation of the patient into the family unit with, most importantly, the acceptance by one and all, is most desirable. This helps him to adjust to the new way of life and a new body image.

Rapport and understanding must be established in the husband/wife relationship.

The patient must be helped to cope with embarrassing questions by family, friends and neighbours. Simple explanations should be given and grandchildren can be helped to understand that grandmother or grandpa has a sore tummy.

District services

District stomatherapy services are available in some areas. The stomatherapist gives a very important general back-up service to the patient and family and assists with dressings and ongoing stoma care until the patient learns to manage more and more on his own.

The district sister provides continual control over repeat hospital visits and over correct use of equipment without hoarding and wastage.

Going on holiday

Once the trauma and having to learn to cope with a new type of existence is over it is good to look forward to a change of environment and tempo.

The idea of going away often makes the aged feel uncertain and it can be impossible for them to apprehend their own personal ability in learning to cope with their new way of life in a different environment. Initially, day trips and outings to family and friends who understand the problem helps to boost their morale.

It is important that the ostomate:

- feels confident in travelling distances
- is sure that suitable accommodation is available when he arrives at the destination
- knows that hot and cold water will be available.

A holiday or a trip away from home should not be delayed, for the sense of achievement and progress is of immeasurable value to the colostomist.

Customs

Stoma bags keep well if removed from the large containers and put into freezer bags and packed away amongst clothing. If the colostomist is anxious about possible embarrassment caused by custom officials, an appropriate covering letter stating the function of the equipment can be submitted by the stomatherapist.

A few of each appliance should always be carried in the hand baggage to avoid any problems caused by hold-ups or loss of luggage. The ostomate should have supplies of Immodium and Senna or other appropriate antidiarrhoeals or aperients on hand in case of problems due to a change in diet.

Once the first holiday is undertaken the whole world opens up, bringing with it a great sense of freedom and confidence.

Other factors which can be troublesome in stoma care for the aged

Alcoholism may become a problem — if the ostomate has or has had a

problem with alcohol, he usually reverts to alcohol. When alcohol intake is increased there is a coinciding increased output.

Poor eye sight can be very afflictive. The ostomate has to use a *feel technique* and what eye sight he has left in application of the bags. Joints affected by arthritis are often painful and reduce nimbleness of finger movements considerably.

Very often the elderly person has been hail and hearty for years — “*Never been sick in my life.*” Now all of a sudden he has what can be described as fairly mutilative surgery- and into the bargain ends up wearing a **bag**. Here comprehension and insight into the surgical procedure is very important.

Conclusion

A positive attitude by the staff and family that the patient **can** and **will** cope, even though it is difficult to adjust to the new lifestyle, is essential. Things can only improve and talking to other ostomates to whom they can relate is of great assistance to the stoma patient.

BOOK REVIEW

BOEKRESENSIE

CURRENT ISSUES IN NURSING

Joanne C McCloskey and Helen K. Grace
Massachusetts: Blackwell Scientific Publications 1981

793 pages (paperback)

This book is divided into 12 sections and probes deeply into basic issues which lie at the heart of nursing namely nursing knowledge, changing education, changing practice, quality assurance, governance, government intervention, cost effectiveness, personnel and political assertiveness, role conflict, cultural diversity and ethics.

In each section the issue is debated and is followed by a series of articles in which leading American nurses give their views. The authors have prefaced each section with a helpful overview of the main ideas presented.

The issues raised are relevant to the nursing profession in any country but the discussion must be understood within the context of American nursing.

In the section on quality assurance the question is posed on how to ensure that registered nurses remain professionally competent so that quality care is rendered. Issues such as mandatory continuing education for relicensing, licensing, accreditation and certification are discussed. The question is posed whether credentials protect the public or the profession and whether they assure quality of care for the consumer.

In the debate on economic issues nursing care is reckoned as cost effective because care, support and assistance is given to the patient. If she were not there someone else would have to be found to look after the patient. On the other hand it is not cost effective because of the high staff turnover, ineffective use of man-

power and outmoded methods of nursing practice. In the series of articles that follow the cost of nursing education, the use of computers, and management information systems for planning care, recording medication, ordering and keeping records of supplies, monitoring and staff allocation are discussed. Will nursing administrators be able to prepare themselves quickly enough for their function as managers.

Nurses are frequently asked for information and advice by patients. What do nurses do when the doctor withholds information? Does the patient not have the right to know what is wrong with him? Does the nurse as an independent practitioner have the right to tell the patient about his treatment even when the doctor is withholding information. Two articles are presented on the case of a clinical supervisor who gave a terminally ill patient advice on treatment that was different to the Doctor's. The nurse eventually won the case. The complicated decisions involved in euthanasia because of ethical and legal implications is discussed in several articles. This issue, the ethical dilemmas of abortion and the difficulty of choosing between two or more unsatisfactory alternatives are all problems for which the nursing profession must find answers.

This book stimulates thought and provides the reader with good insight into contemporary nursing in America. It requires the South African nurse to take up these issues, debate them and find answers for them within the nursing context of this country. This book could be read by all registered nurses and will be especially helpful to administrators, educators and all nurses doing post-basic studies. There should be a copy in all libraries.

B Robertson