Ostomy Management: Prolapsed Stoma Pouching Procedure

Site Applicability

All VCH & PHC sites – acute, community and residential

Practice Level

Basic skills for the following professions (within their respective scope of practice):

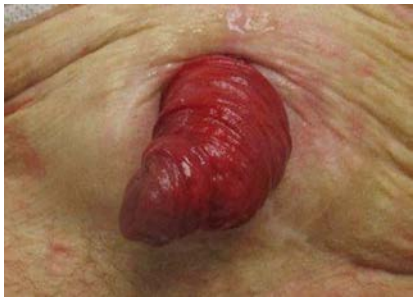
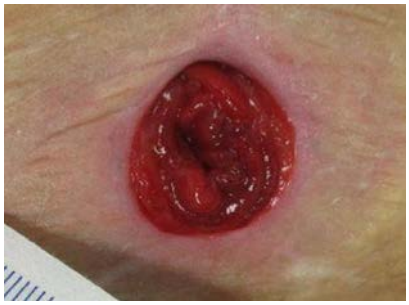
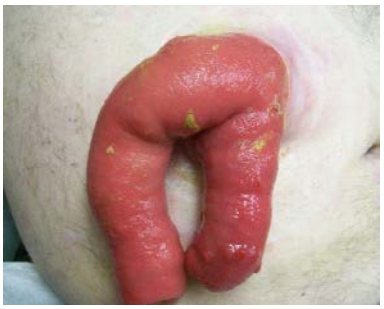
- RN, LPN, RPN
- ET/WOCN/NP

Policy Statement

All nursing designations must practice within their scope of practice for the care of a prolapsed stoma.

Need to Know

- A prolapsed stoma is defined as a stoma that develops a length longer than what was created during surgery. This is a common stomal complication occurring any time beyond the initial post-operative period. Prolapse can occur with any type of stoma but it is most prevalent in loop ostomies and transverse colostomies.

Stoma A	Stoma A	Stoma B
		
Prolapsed end stoma in sitting or standing	Retracted end stoma in supine position	Prolapsed loop ileostomy

- Stoma prolapse can be characterized as either sliding (length of stoma increases or telescopes when patient/client/resident goes from a reclining to a standing position) or fixed (length does not vary).
- Stoma length can be anywhere from 3 cm (1st degree prolapse), 5 cm (2nd degree prolapse), or up to 60 cm (3rd degree prolapse).
- Etiology of a prolapsed stoma:
  - Large fascial opening created during surgery (a risk with intestinal edema).
  - Inadequate fixation of the bowel to the internal abdominal wall.
  - Emergency stomal surgery (lack of peri-operative stomal marking over the rectus abdominus muscle).
  - Increased intra-abdominal pressure (coughing, constipation, crying, heavy lifting, tumour, ascites).
  - Deconditioned abdominal muscles.
  - Increased occurrence seen with obesity, pregnancy, advanced age, spinal cord injury.
- Stomal prolapse is not a life threatening condition but an MD, NP or ET/WOCN should be consulted to assess for obstruction, ischemia or necrosis as this may require surgical management/revision.

- Stomal prolapse may cause anxiety for client and/or family or caregivers due to client's altered body image, and/or appearance of prolapsed stoma. A referral to an ET/WOCN for emotional support and resources/referral may be helpful to reduce anxiety. Surgical management/revision can be employed for cosmetic reasons if a prolapse causes significantly decreased quality of life.
- If the patient/client/resident experiences leakage, stomal trauma or peri-stomal skin issues with their prolapsed stoma, they should be assessed by their local ET/WOCN Nurse for re-evaluation of the ostomy appliance.
- A skin barrier accessory product may be needed to protect the peristomal skin from effluent if too much skin is exposed (Clinical Decision Grid for Ostomy Accessory Products).
- Use of a support garment or hernia belt with a prolapse flap can be effective in holding the stoma in a retracted position. Consult with an ET/WOCN Nurse to have patient/client resident measured and fitted for a support garment.

Equipment & Supplies

Ostomy Equipment:

- Cleaning cloths (e.g. paper towels, face cloths, gauze)
- Stoma measuring guide
- Scissors
- Ostomy appliance
- Accessory products (if applicable) (Clinical Decision Grid for Ostomy Accessory Products)
- Garbage bag for old appliance
- Support belt/garment (if applicable)

See also:

- Procedure for Changing a One or Two-Piece Fecal Ostomy Pouching System with or without a Rod
- Procedure for Changing a One or Two-Piece Urostomy (ileal conduit) Pouching System
- Ostomy Assessment and Management

Practice Guideline

Prolapsed stoma pouching procedure

Practice	Rationale
1. Gather necessary supplies and explain the procedure to the patient/client/resident.	
2. Perform hand hygiene and put on personal protective equipment.	Clean technique required, use universal precautions.
3. Remove old appliance and clean stoma with warm water and paper towel/cloth.	Cleaning products other than water may cause skin irritation/sensitivity.
4. Assess stoma for signs of trauma (laceration/cut, yellowish-white linear discoloration) and assess removed pouching barrier and peristomal skin for evidence of leaking (Ostomy Assessment and Management).	Leaking, skin issues or trauma to the stoma can be signs of an inappropriate pouching system or pouch placement.
5. Using an ostomy measuring guide, measure the stoma base with the patient/client/resident in a **standing/high Fowler's position or in the position where the stoma is at maximum size.**	The base size of a prolapsed stoma may increase when standing. Measurement must be taken with the stoma at its maximum size to avoid cutting the flange too small, mitigating stomal trauma and reducing risk of flange leakage. A high Fowler's position may be used if standing is not feasible.

6. Using the measuring guide, trace the appropriate size for the stoma onto the back of the flange.	Measuring will ensure a more accurate fit.
7. Cut the flange 2 to 3 mm larger than the actual size of the prolapsed stoma.	The flange may leak if cut too small or too large. A flange cut too large may lead to peri-stomal skin irritation.
8. Ensure the flange is the proper size by placing it around the stoma on the abdomen with the adhesive backing still in place.	You can continue to make adjustments to the flange if the size is incorrect without compromising the adhesive.
9. Have the patient/client/resident move to a reclining position so the stoma can retract. You may be able to encourage the stoma to retract by applying direct hand pressure or by using cold compresses.	The appliance will be easier to apply when the stoma is in a retracted position.
10. Ensure the peri-stomal skin is dry.	The appliance will not adhere to moist skin.
11. Remove the plastic/paper backing from the flange.	
12. **If using a 1 piece system:** Place the flange around the stoma and secure to the abdomen. Ensure the cut edge of the appliance is well adhered. **If using a 2 piece system:** Either attach the flange to the pouch and apply as a 1 piece system or place flange around the stoma and secure to the abdomen. Ensure the cut edge of the appliance is well adhered. Then attach pouch to the flange as per product manufacturer. Caution against pinching enlarged stoma when attaching pouch to flange. (Procedure for Changing a One or Two-Piece Fecal Ostomy Pouching System with or without a Rod)	The cut edge of the flange must be well adhered to the abdomen to avoid leakage of effluent. It is a matter of preference or ease whether a 2 piece system is pre-assembled or not.
13. If the patient/client/resident is using a support belt/garment, apply before they stand.	A support belt/garment should be applied while the prolapsed stoma is retracted.
14. If the patient/client/resident is not using a support belt/garment, ask them to stand and ensure the flange is not obstructing the stoma in the prolapsed position.	The flange may cause bleeding or trauma to the prolapsed stoma if not properly applied.

Expected Patient/Client/Resident Outcomes

The patient/client/resident will have a greater understanding of their prolapsed stoma and how to avoid fit issues or stomal trauma from their ostomy appliance.

Patient/Client/Resident Education

- Patient/client/resident will contact surgeon or ET/WOCN nurse in the event of severe peri-stomal pain or stoma colour turning dusky, purple or black.
- Patient/client/resident knows how to apply an ostomy appliance with a prolapsed stoma.

Documentation

As per agency protocol.

Related Documents

- Ostomy Assessment and Management
- Procedure for Changing a One or Two-Piece Fecal Ostomy Pouching System with or without a Rod
- Procedure for Changing a One or Two-Piece Urostomy (ileal conduit) Pouching System
- Clinical Decision Grid for Ostomy Accessory Products

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