

Case Study Using Adapt Barrier Rings

Overview

Mrs. R is a 71-year-old that had an ileostomy fashioned a year ago. Her past medical history (PMH) includes three lower segment caesarean sections, with the last one 38 years ago. She suffered a post-operative clot and a second clot in 1993, which was treated with heparin and warfarin. Warfarin was stopped due to diabetic retinopathy.

Gangrene of her right foot resulted in an above-the-knee amputation. She was presented to the surgical team in 2004 with a presumed abdominal abscess. It was later found to be a large incisional hernia that had fistulated cutaneously.



Problem: Mrs. R's husband was trying to manage the treatment of the fistula independently at home with dry dressings. The stoma care team reviewed her and gave her pouches to try. But these would not stay in situ due to the position of the fistula; underneath a huge skin fold. In March 2007, she was admitted to hospital with abdominal sepsis and three high output fistulae. She underwent surgery one month later. A laparotomy revealed multiple abdominal wall herniae, a midline fistula and a small-bowel fistula. A loop ileostomy was fashioned proximal to the repaired fistula.

At four days post-operatively, she developed a localised collection in the LIF (left Iliac fossa). The laparotomy wound broke down with a fistula between the distal small bowel and the open laparotomy wound.

The pictures above show the open laparotomy wound and fistulae.



The above photos show the fistulae healing and closure of the laparotomy wound.

The wound became very sloughy, as it was constantly contaminated with small bowel content. But the ileostomy continued to work. Initial management included using a large wound manager over Hollister **Adapt** Barrier Rings. This pouched both the wound and stoma, since it was impossible to isolate one from the other.

The surgeons were concerned that the wound would not heal with constant contamination, therefore, the stoma care specialists reassessed. A finger was inserted into the laparotomy wound, which demonstrated a communication with the stoma via a skin bridge. It was thought that faeces was leaking between the two areas. A decision was made to attempt to plug the gap to prevent the flow. This was done by placing a silastic foam-type dressing into the wound and tract. This initially worked well, however due to copious amounts that were being passed, the dressings were leaking. A decision was made to pouch both the wound and stoma together again. Once Mrs. R's husband was able to carry out her care, she was discharged home on this regimen. The district nurses were available to support them at home.

Solution:

Healing accelerated and the stoma care specialists reviewed the patient every one to two weeks.

As the area began to granulate and subsequently heal, she was able to pouch the stoma alone. A convex pouch would have been ideal. However, in practice, this was not successful due to the deep crease that was directly underneath the stoma. Many different types of convex pouches were tried and found not to work due to the very large ridge and skin fold directly under the stoma.

Therefore, it was decided that a large Adapt Barrier Ring should be used prior to pouch application. The Hollister Adapt Barrier Rings are made from a **Flextend M** barrier that offers extended wear time due to its unique fluid handling properties (suitable for perspiration and stoma effluent). They are extremely malleable, and can be moulded into all the skin creases. This creates a flat surface area, so a flange can be securely attached to it.



This picture shows the crease at 7 o'clock that will be filled with half of a large Adapt Barrier Ring.

The pictures below show half of a large Adapt Barrier Ring being applied into a dip next to the stoma. This helps to fill a crease that is a result of a healed area.



Her peristomal skin, however, was excoriated. **Adapt** Powder was applied liberally to the weeping areas prior to pouch application.

Mr. and Mrs. R put a thin line of **Adapt** Paste around the barrier ring. This helps maintain a seal as it fills any further skin creases.



The pictures above show the crease now filled with half of a large Adapt Barrier Ring.



The picture above shows the Adapt Paste that is used to help maintain a seal and fill skin creases, prior to pouch application.

A whole Adapt Barrier Ring is then placed around the stoma, moulding it into shape



The pictures above show a whole large Adapt Barrier Ring sitting over the half barrier ring.

Outcome:

Her recovery and management at home was only made possible due to the capabilities of her husband, who has been very involved in all aspects of her care.

Psychologically, this patient was always willing to try new treatments. Despite her disabilities, she has remained positive. The leakages appeared to never overly concern this patient, even though at times her peristomal skin was extremely excoriated and sore. The benefits of the Adapt Barrier Rings and Adapt Paste were considerable with regard to comfort, flexibility and enabling a longer wear time by this patient.

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