

Summary and Conclusion

Intestinal Stomas are surgically constructed opening of part of intestine on the anterior abdominal wall aiming at decompression or diversion of normal intestinal passage due to wide range of diseases .

Intestinal stomas can be classified into; temporary stomas to protect a distal anastomosis or a pouch, defunction distal diseased or injured bowel, relief an obstruction and protect anal operations e.g anal fistulas or sphincter repair while Permanent stomas are created after resection of bowel for benign disease, e.g proctocolectomy for Crohn's disease, after resection of bowel for pre-malignant disease, e.g Familial adenomatous polyposis, after resection of bowel for malignant disease.

A decompressing stoma does not necessarily provide diversion of feces. These stomas are constructed most often for distal obstructing lesions causing massive dilation of the proximal colon without ischemic necrosis, severe sigmoid diverticulitis with phlegmon, and for select patients with toxic megacolon, while diverting stoma is constructed to provide diversion of intestinal content. It is performed when the distal segment of bowel has been completely resected because of known or suspected perforation or obstruction of the distal bowel or because of destruction or infection of the distal colon, rectum, or anus.

Continent perineal colostomy after APR can be constructed using many techniques including; Graciloplasty (single or double), Electro-stimulated (dynamic) graciloplasty, Gluteoplasty with pudendal nerve anastomosis, Smooth muscle wrap, Artificial neosphincter implantation or Lazaro di Silva technique.

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A continent ileostomy is similar to an end ileostomy, but rather than having to wear an external pouch, an internal pouch is created inside the abdomen. A valve is implanted into the skin so that the pouch can be emptied using a catheter. The end of the ileum is bent back inwards, to create a pouch that is stapled into place against the side of the abdomen. A smaller section of the ileum is used to create a valve, which is pulled through a stoma in the abdomen and then stitched into place. The internal pouch can then be emptied with a catheter.

Disadvantages of transverse loop colostomy include: Bulky and bad site for appliances to fit. Loose effluent leads to skin excoriation and offensive smells and tendency to prolapse and parastomal hernia. possibility to damage marginal artery at closure with high incidence of wound infection at closure

The consequences of leakage from low colorectal or coloanal anastomoses are reduced by the use of a loop stoma to divert the faecal stream. The potential stoma sites should be marked preoperatively. The site should be marked with the patient in both the sitting and supine positions to ensure that the stoma appliance fits securely.

There is a wide range of different pouches that the patient can use such as a one piece pouch and a two piece pouch which consists of a semi-permanent stoma attachment that can be worn for 5-7 days, which can be attached to disposable pouches as required. Colostomy pouches are made from hypoallergenic (non-allergic) material in order to reduce skin irritation, and they contain special wafers that ensure that the pouch does not release any unpleasant odours.

There are many surgical approaches by which construction and closure of stoma can be performed. That can be hand made or using staplers saving time and effort. Also stomas can be constructed and closed laparoscopically in well equipped centers.

Laparoscopic ileostomy and colostomy creation have been performed for a plethora of indication. The technique allows the surgeon to evaluate the liver and peritoneum for the presence of metastases that may be undetected on the preoperative imaging studies, and institute fecal diversion without creating adhesions in the abdomen and pelvis that may increase toxicity of neo adjuvant radiotherapy and make future proctectomy more difficult. The absence of laparotomy incision allows patients to recover rapidly, and allows them to begin neoadjuvant radiotherapy treatments almost immediately.

Many complications may follow construction of stomas such as skin maceration, obstruction, prolapse, electrolyte imbalance and psychological embarrassment. Proper choosing the stoma site plays an important role in prevention of complications.

Care of the stoma is the corner stone in management of patients undergoing operation for stoma construction. Proper care of wound prevents skin complications.

Intestinal Stoma is not a disease, but a change in the way the body works. It surgically changes normal body function to allow stool to pass after a disease or injury through an opening that is surgically created on the anterior abdominal wall. People with stomas can enjoy normal life and wide range of activities allowing proper communication with the society. Many organizations are concerned with ostomates for proper

support. They can provide help, information and communications with other people with stomas.

Conclusion

Stomas continue to play an important role in management of colorectal diseases. Advances in surgical technology and in the concepts of management have led to decrease the numbers of permanent stomas. Loop ileostomy is as good as loop colostomy when a temporary defunctioning stoma is indicated. The outcome depends primarily on the surgical technique rather than the type of stoma. Preoperative patient counseling and stoma site marking together with postoperative patient education and stoma care is important. Laparoscopic or trephine stomas can be raised with minimal morbidity in patients not requiring laparotomy. Complications of stomas remains common, careful surgical technique and early stoma care improve the overall patient management.