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Colostomy Guide

Colostomy surgery is done for many different diseases and problems. Some colostomies are done because of cancer; others are not. For instance, a child may need one because of a birth defect. Depending on the reason or type of problem, a colostomy may be needed for a short time (temporary) or it may be needed for the rest of a person's life (permanent).

For the thousands of people who have serious digestive diseases, a colostomy can be the start of a new and healthier life. If you've had a chronic problem or a life-threatening disease like colorectal cancer, you can look forward to feeling better after you recover from colostomy surgery. You can also look forward to returning to most, if not all of the activities you enjoyed in the past.

This guide will help you better understand colostomy – what it is, why it's needed, how it affects the [normal digestive system](#), and what changes it can bring to a person's life.

- [What Is a Colostomy?](#)
- [Types of Colostomies and Pouching Systems](#)
- [Caring for a Colostomy](#)

What Is a Colostomy?

A colostomy is an opening in the belly (abdominal wall) that's made during surgery. It's usually needed because a problem is causing the colon to not work properly, or a disease is affecting a part of the colon and it needs to be removed. The end of the colon

(large intestine) is brought through this opening in the skin to form a *stoma*. A colostomy might only be needed for a short time (temporary), maybe for 3 to 6 months. A temporary colostomy may be used when a part of the colon needs time to rest and heal from a problem or disease. But sometimes a disease, such as cancer, is more serious and a colostomy may be needed for the rest of a person's life (permanent).

Where the colostomy stoma will be on the abdomen depends on which part of the colon is affected. Some colostomies are large, some small; some are on the left side of the abdomen, some are on the right, others may be in the middle. A Wound Ostomy Continence nurse (WOCN or WOC nurse) or the surgeon will figure out the best location for your stoma. (A WOC nurse is a specially-trained registered nurse who takes care of and teaches ostomy patients. This nurse may also be called an ostomy nurse.)

When you look at a stoma, you are actually looking at the lining (the *mucosa*) of the intestine, which looks a lot like the inside lining of your cheek. The stoma will look pink to red. It's warm and moist and secretes small amounts of mucus.

The way the stoma looks depends on the type of colostomy the surgeon makes and on individual body differences. It may look quite large at first, but will shrink to its final size about 6 to 8 weeks after surgery. The shape will be round to oval. Some stomas may stick out a little, while others are flat against the skin.

Unlike the anus, the stoma has no valve or shut-off muscle. This means you won't be able to control stool passing from the stoma, but sometimes bowel movements can be managed in other ways. There are no nerve endings in the stoma, so the stoma itself is not a source of pain or discomfort.

What does a colostomy do?

A colostomy changes the way your body works to allow stool to pass. After a colostomy has been created, the intestines will work just like they did before except:

- The colon and rectum beyond the colostomy are disconnected or removed.
- The anus is no longer the exit for stool, but it will still pass mucus from time to time. This is normal.

Since nutrients are absorbed in the small intestine, a colostomy does not change how the body uses food. The main functions of the colon are to absorb water, move the stool toward the anus, and then store stool in the rectum until it's passed out of the body. When a colostomy changes the stool's route, the storage area is no longer available.

The higher up in the colon the colostomy is made, the shorter the colon is. A shorter colon means it has less time to absorb water, making the stool softer or more liquid. A colostomy further down in the colon, near the rectum, will put out stool that has been in the intestine a longer time. Depending on the effects of illness, medicines, or other forms of treatment, the longer colon can put out a more solid or formed stool. Some people with colostomies find that they are able to pass this stool at certain times of the day with or without the help of irrigation. (See [Caring for a Colostomy](#).)

After surgery, some people still may feel urges and even have some discharge from the anus. This discharge is mucus, blood, and at times stool, left from the operation. If the rectum remains after surgery, it will keep putting out mucus that can be passed harmlessly whenever you have the urge.

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In its original form this document was written by the United Ostomy Association of America (1962-2019). It has since been modified and updated by the American Cancer Society using the following sources.

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Types of Colostomies and Pouching Systems

A colostomy can be short-term (temporary) or life-long (permanent) and can be made in any part of the colon. The different types of colostomies are based on where they are located on the colon.

Temporary colostomies

Certain lower bowel problems are treated by giving part of the bowel a rest. It's kept empty by keeping stool from getting to that part of the bowel. To do this, a short-term (temporary) colostomy is created so that the bowel can heal. This healing process usually takes a few weeks or months, but may take years. In time, the colostomy will be reversed (removed) and the bowel will work like it did before – the stool will exit from the anus again.

Permanent colostomies

When part of the colon or the rectum becomes diseased, a long-term (permanent) colostomy must be made. The diseased part of the bowel is removed or permanently rested. In this case, the colostomy is considered permanent and is not expected to be closed in the future.

Transverse colostomies

A transverse colostomy is one of the most common types. There are 2 types of transverse colostomies: the loop transverse colostomy and the double-barrel transverse colostomy. The transverse colostomy is in the upper abdomen, either in the middle or toward the right side of the body. This type of colostomy allows the stool to leave the body before it reaches the descending colon. Some of the colon problems that can lead to a transverse colostomy include:

- Diverticulitis. This is inflammation of diverticula (little sacs along the colon). It can cause abscesses, scarring with stricture (abnormal narrowing), or rupture of the colon and infection in severe cases.
- Inflammatory bowel disease
- Cancer
- Obstruction (blockage)
- Injury
- Birth defects

If there are problems in the lower bowel, the affected part of the bowel might need time to rest and heal. A transverse colostomy may be used to keep stool out of the area of the colon that's inflamed, infected, diseased, or newly operated on – this allows healing to take place. This type of colostomy is usually temporary. Depending on the healing process, the colostomy may be needed for a few weeks or months, but possibly for years. If the colon heals over time, the colostomy is likely to be surgically reversed (closed). You will have normal bowel function after it's reversed.

A permanent transverse colostomy is made when the lower portion of the colon must be removed or permanently rested, or if other health problems make the patient unable to have more surgery. The colostomy is then the permanent exit for stool and will not be closed in the future.

Loop transverse colostomy (Figures 2 and 3): The loop colostomy may look like one very large stoma, but it has 2 openings. One opening puts out stool, the other only puts out mucus. The colon normally makes small amounts of mucus to protect itself from the bowel contents. This mucus passes with the bowel movements and is usually not noticed. Despite the colostomy, the resting part of the colon keeps making mucus that will come out either through the stoma or through the rectum and anus. This is normal and expected.

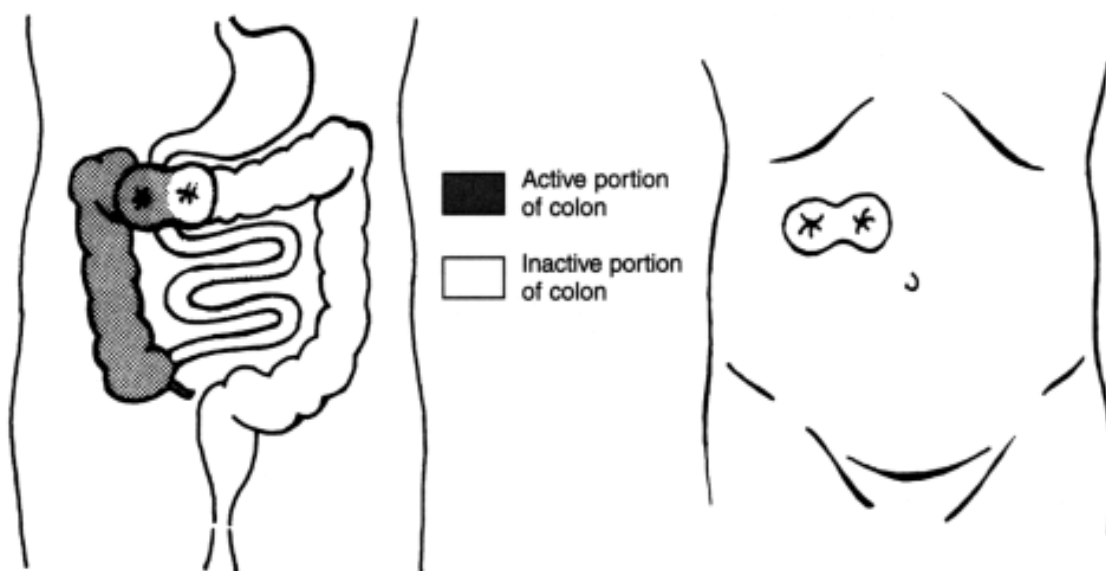


Figure 2
Loop Transverse Colostomy

Figure 3
Loop Transverse Colostomy

Double-barrel transverse colostomy (Figures 4 and 5): When creating a double-barrel colostomy, the surgeon divides the bowel completely. Each opening is brought to the surface as a separate stoma. The 2 stomas may or may not be separated by skin. Here, too, one opening puts out stool and the other puts out only mucus (this smaller stoma is called a mucus fistula). Sometimes the end of the inactive part of the bowel is sewn closed and left inside the belly. Then there's only one stoma. The mucus from the resting portion of the bowel comes out through the anus

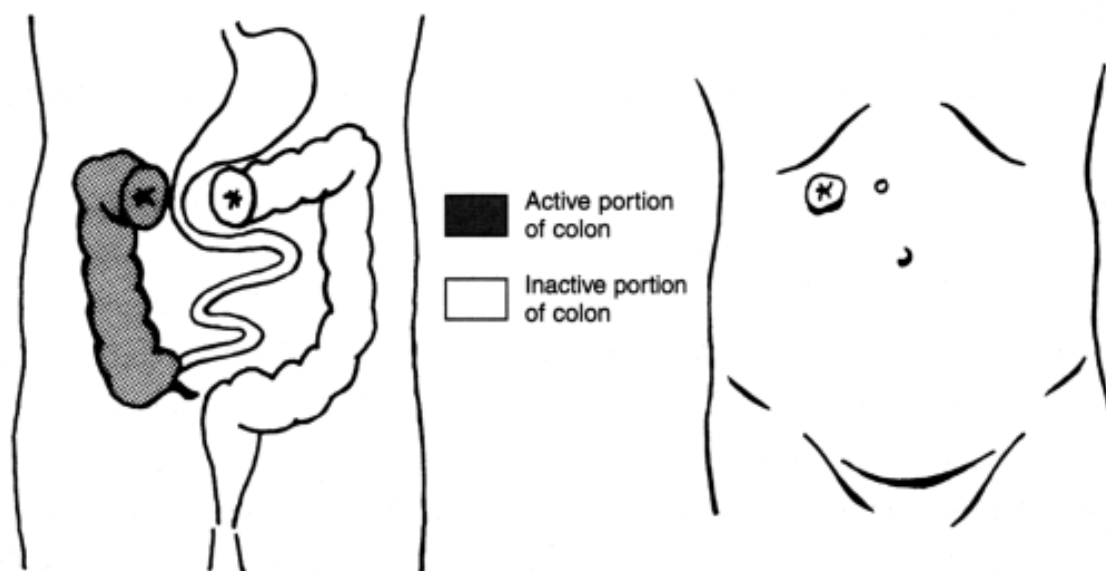


Figure 4
Double-Barrel Transverse Colostomy

Figure 5
Double-Barrel Transverse Colostomy

Changes in the newly formed transverse colostomy

Right after surgery, your colostomy may be covered with bandages or it may have a clear pouch over it. The type of pouch used right after surgery is usually different from those you'll use at home. Before you look at your colostomy for the first time, keep in mind that it may be quite swollen after surgery; there may also be bruises and stitches. While a stoma normally is moist and pink or red in color, it may be darker at first. Your stoma will change a lot as it heals. It will get smaller and any discoloration will go away, leaving a moist red or pink stoma. This may take several weeks.

You'll soon notice that, although you can usually tell when your colostomy is going to pass stool or gas, you can't control it. Your colostomy does not have a valve-like sphincter muscle like your anus does. Because of this, you'll need to wear a pouch over your colostomy to collect the output. Your ostomy nurse or doctor will help you find a pouching system that's right for you. This is also discussed in more detail below in "Choosing a colostomy pouching system."

Managing a transverse colostomy

When a colostomy is made in the right half of the colon (near the ascending colon), only a short portion of colon leading to it is active. The stool that comes out of a transverse

colostomy varies from person to person and even from time to time. A few transverse colostomies put out firm or paste-like stool at infrequent intervals, but most of them move often and put out soft or loose, oatmeal-like stool.

It's important to know that the stool contains digestive enzymes (chemicals made by the body to break down food). These enzymes are very irritating, so the nearby skin must be protected with a skin barrier. (See "Protecting the skin around the stoma" under [Caring for a Colostomy](#) for more on this.)

Trying to control a transverse colostomy with special diets, medicines, enemas, or irrigations usually doesn't work and is not usually advised. In most cases, a pouching system is worn over a transverse colostomy at all times. A lightweight, drainable pouch holds the output and protects the skin from contact with the stool. The pouch doesn't usually bulge, and it's not easy to see under your clothes.

Bowel movements with a transverse colostomy

A transverse colostomy will put out stool no matter what you do. Keep in mind these points:

- The right pouching system (also called an appliance) for you is one that will keep you from soiling your clothing.
- The firmness of your stool is affected by what you eat and drink.
- Gas and odor are part of the digestive process and cannot be prevented. But they can be controlled. Your pouch will help to control odors.
- Empty the pouch when it's about 1/3 to 1/2 full to keep it from leaking or bulging under your clothes. It's best to arrange a space in your bathroom at home, and to find a bathroom when you're out, where you can empty your pouch.
- Change the pouch system before there's a leak. It's best to change it no more than once a day and not less than once every 3 or 4 days.
- The ostomy output can irritate your skin. You can help prevent skin problems by having a correctly fitted pouch system and by using special materials for ostomy care.

Ascending colostomy

The ascending colostomy is placed on the right side of the belly. Only a short portion of colon remains active. This means that the output is liquid and contains many digestive

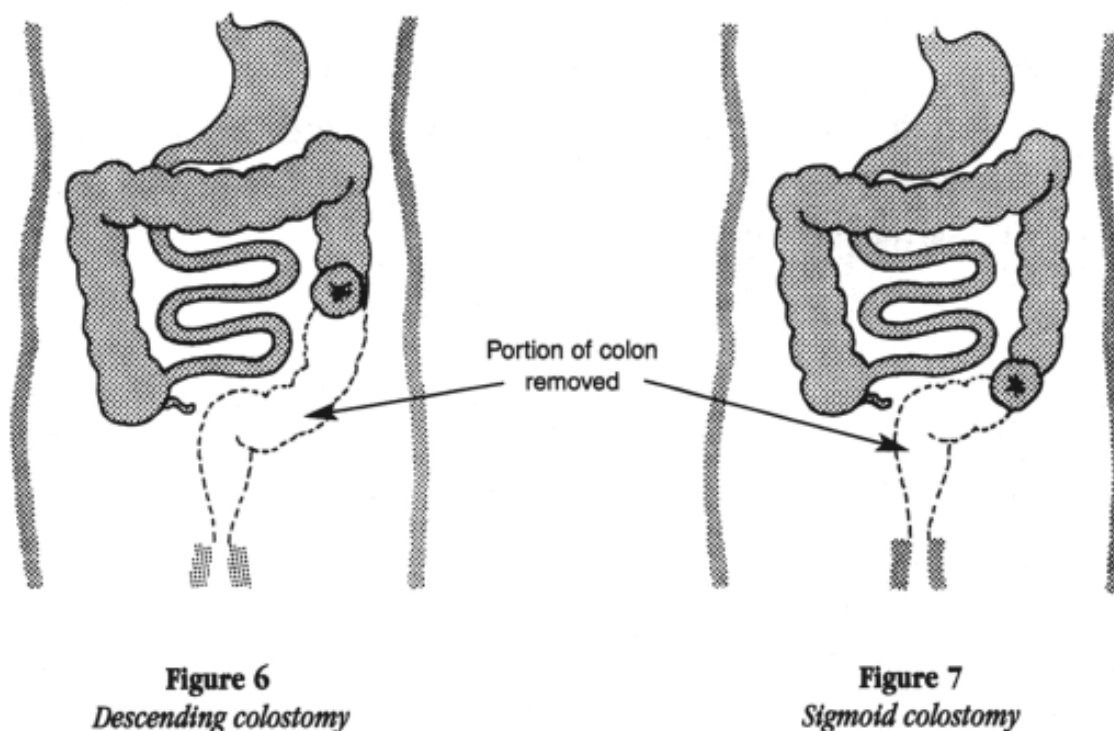
enzymes. A drainable pouch must be worn at all times, and the skin must be protected from the output. This type of colostomy is rare because an ileostomy is often a better choice if the discharge is liquid. (For more on this, see [Ileostomy: A Guide¹](#).)

Caring for an ascending colostomy is much like caring for a transverse colostomy (as discussed above).

Descending and sigmoid colostomies

Located in the descending colon, the descending colostomy (Figure 6) is placed on the lower left side of the belly. Most often, the output is firm and can be controlled.

A sigmoid colostomy (Figure 7) is the most common type of colostomy. It's made in the sigmoid colon, and located just a few inches lower than a descending colostomy. Because there's more working colon, it may put out solid stool on a more regular schedule.



Both the descending and the sigmoid colostomies can have a double-barrel or single-barrel opening. The single-barrel, or end colostomy, is more common. The stoma of the end colostomy is either sewn flush with the skin or it's turned back on itself (like the

turned-down top of a sock).

You will notice with a descending or sigmoid colostomy:

- The stool is firmer or more like paste. It doesn't have as much of the irritating digestive enzymes in it.
- Stool output may happen as a reflex at regular, expected times. The bowel movement will take place after a certain amount of stool has collected in the bowel above the colostomy. Two or 3 days may go between movements
- Spilling may happen between movements because there's no muscle to hold the stool back. Many people use a lightweight, disposable pouch to prevent accidents
- Feeling the need to empty the bowel (reflex) will happen quite naturally in some people. Others may need mild stimulation, such as juice, coffee, a meal, a mild laxative, or irrigation.

Bowel movements with a descending or sigmoid colostomy

A bowel movement through a colostomy happens naturally like a normal movement through the anus. But, unlike the anal opening, the colostomy does not have nerves or a sphincter muscle that can help to stop the passage of stool.

- You must wear a pouch to collect anything that might come through, whether it's expected or not. Many lightweight pouches are hard to see under clothes. They stick to the skin around the colostomy and may be worn all the time, or only as needed.
- For some people, eating certain foods at certain times can make the bowel move at a time that works best for them. Some people use only this method to keep bowel movements on a regular schedule, while others use it with irrigation.

Constipation or loose stool

Many people think that you must have a bowel movement every day. In truth, this varies from person to person. Some people have 2 or 3 movements a day, while others have a bowel movement every 2 or 3 days or even less often. It may take some time after surgery to figure out what's normal for you.

While many descending and sigmoid colostomies can be trained to move regularly,

some cannot. Training, with or without stimulation, is likely to happen only in those people who had regular bowel movements before they became ill. If bowel movements were irregular in earlier years, it may be hard, or impossible, to have regular, predictable colostomy function. Spastic colon, irritable bowel, and some types of indigestion are some conditions that cause people with colostomies to continue to have bouts of constipation or loose stool.

Closing or reversing a colostomy

If you're going to have your colostomy closed, the surgeon might mention plans to "take it down" or "reverse it" in a few weeks or months, but sometimes the doctor doesn't say anything about it. It's best to talk to your surgeon about these things before you leave the hospital so you know what the plans are and when to see the surgeon again. If you're at home now and didn't get instructions, call the doctor's office or clinic and find out what the doctor wants you to do. It's your job to stay in touch with the doctor.

Many things must be taken into account when thinking about closing a colostomy, such as:

- The reason you needed the colostomy
- Whether you can handle more surgery
- Your health since the operation
- Other problems that may have come up during or after surgery

Choosing a pouching system

Deciding what pouching system or appliance is best for you is a very personal matter. When you're trying out your first pouching system, it's best to talk with an ostomy nurse or someone who has experience in this area. There should be someone in the hospital who can get you started with equipment and instructions after surgery.

As you're getting ready to leave the hospital, be sure you are referred to a Wound Ostomy Continence nurse (WOCN or WOC nurse, also called an *ostomy nurse*), a clinic, an ostomy manufacturer, or a chapter of the United Ostomy Associations of America. Even if you must go out of town to get such help, it's worthwhile, as you want to get a good start and avoid mistakes. Even with help, you may have to try different types or brands of pouching systems to find the one that best suits you. (See [Getting Colostomy Help, Information, and Support²](#).)

There are many things to think about when trying to find the pouching system that will

work best for you. The length of the stoma, abdominal firmness and shape, the location of the stoma, scars and folds near the stoma, and your height and weight all must be considered. Special changes may have to be made for stomas near the hipbone, waistline, groin, or scars. Some companies have custom-made products to fit unusual situations.

A good pouching system should:

- Stay secure, with a good leak-proof seal that lasts for up to 3 days
- Be odor-resistant
- Protect the skin around the stoma
- Be nearly invisible under clothing
- Be easy to put on and take off
- Allow you to shower or bathe with the pouch on, if you wish to do so

Types of pouching systems

Pouches come in many styles and sizes, and an ostomy nurse can help you choose the best one for your situation and lifestyle. They all have a collection pouch to collect stool drainage that comes out of the stoma and an adhesive barrier (called a flange, skin barrier, or wafer) that protects the surrounding skin. There are 2 main types of systems available:

- One-piece pouches have both a pouch and skin barrier attached together in the same unit. When the pouch is removed, the barrier also comes off.
- Two-piece systems are made up of a skin barrier separate from a pouch. When the pouch is taken off, the barrier stays in place.

Some pouching systems can be opened at the bottom for easy emptying. Others are closed and are taken off when they are full. Still others allow the adhesive skin barrier to stay on the body while the pouch may be taken off, washed out, and reused. Pouches are made from odor-resistant materials and vary in cost. They can be either clear or opaque and come in different lengths.

Figures 8 through 15 show some of the different kinds of pouches, plus other supplies that may be needed, such as flanges, clips, and belts (to help hold the pouch in place).

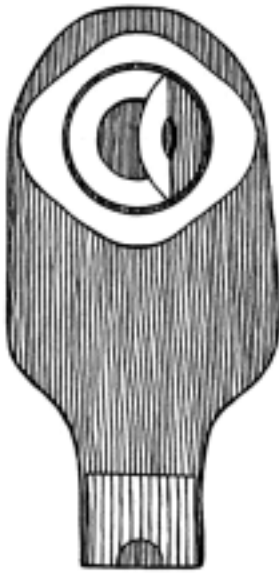


Figure 8
One-Piece Drainable Pouch with Skin Barrier

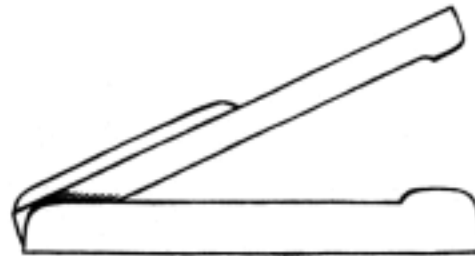


Figure 9
Tail Closure



Figure 10
One-Piece Closed-End Pouch with Skin Barrier



Figure 11
Two-Piece Drainable Pouch

Figure 12
*Flange for Two-Piece Drainable Pouch and for
Two-Piece Closed Pouch*

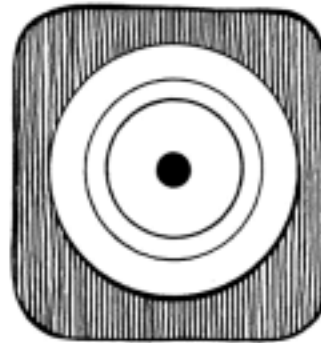


Figure 13
Drainable Pouch Clamp

Figure 14
Ostomy Belt

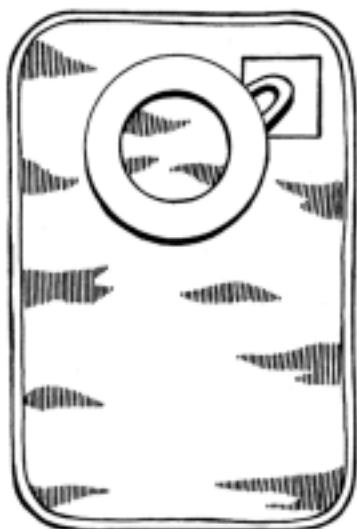
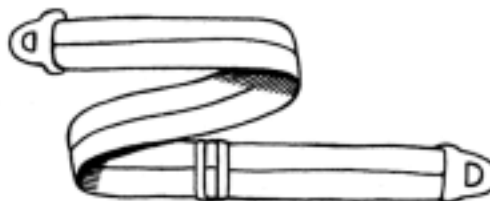


Figure 15
Two-Piece Closed Pouch

The opening of the skin barrier or wafer of the pouch needs to fit your stoma. The opening should be no more than 1/8 inch larger than the stoma. Depending on the pouch design, you may need to cut a hole out for your stoma, or the wafer may be sized and pre-cut. The size of the hole is important because the wafer is designed to protect the nearby skin from the stoma output and be as gentle to the skin as possible.

Keep in mind a stoma's size can change if it becomes swollen or for other reasons. For example, after surgery, your stoma may be swollen for about 6 to 8 weeks. During this time the stoma should be measured about once a week. A measuring card may be included in boxes of pouches, or you can make your own template to match your stoma shape and get the best fit.

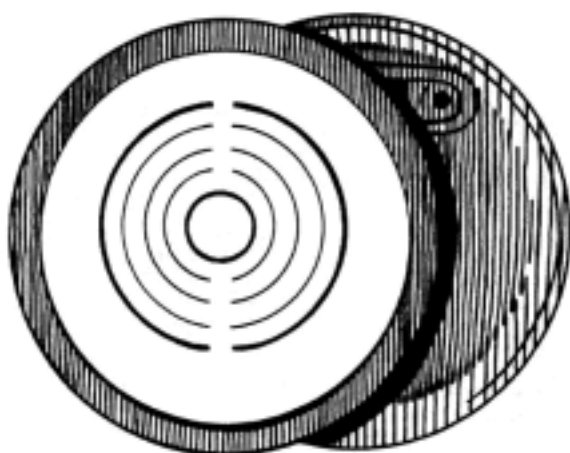


Figure 16
One-Piece Stoma Cap

Stoma cap

If your colostomy puts out stool at regular, expected times, you may be able to use a stoma cover instead of always wearing a pouch. You can place neatly-folded gauze or tissue, dabbed with a small amount of water-soluble lubricant over the stoma, and cover it with a piece of plastic wrap. This can be held in place with medical tape, underclothes, or an elastic garment. Plastic, ready-made stoma caps (Figure 16) are also available.

Hyperlinks

1. www.cancer.org/treatment/treatments-and-side-effects/treatment-types/surgery/ostomies/ileostomy.html
2. [/content/cancer/en/treatment/treatments-and-side-effects/physical-side-effects/ostomies/colostomy/getting-help-info-and-support.html](http://content/cancer/en/treatment/treatments-and-side-effects/physical-side-effects/ostomies/colostomy/getting-help-info-and-support.html)

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Caring for a Colostomy

Protecting the skin around the stoma

The skin around your stoma should always look the same as skin anywhere else on your abdomen. But ostomy output can make this skin tender or sore. Here are some ways to help keep your skin healthy:

Use the right size pouch and skin barrier opening. An opening that's too small can cut or injure the stoma and may cause it to swell. If the opening is too large, output could get to and irritate the skin. In both cases, change the pouch or skin barrier and

replace it with one that fits well.

Change the pouching system regularly to avoid leaks and skin irritation. It's important to have a regular schedule for changing your pouch. Don't wait for leaks or other signs of problems, such as itching and burning.

Be careful when pulling the pouching system away from the skin and don't remove it more than once a day unless there's a problem. Remove the skin barrier gently by pushing your skin away from the sticky barrier rather than pulling the barrier away from the skin.

Clean the skin around the stoma with water. Dry the skin completely before putting on the skin barrier or pouch.

Watch for sensitivities and allergies to the adhesive, skin barrier, paste, tape, or pouch material. They can develop after weeks, months, or even years of using a product because you can become sensitized over time. If your skin is irritated only where the plastic pouch touches it, you might try a pouch cover or a different brand of pouch. A stoma nurse can offer ideas if needed. Pouch covers are available from supply manufacturers, or you can make your own. You may have to test different products to see how your skin reacts to them.

Colostomy irrigation (for descending and sigmoid colostomies only)

Colostomy irrigation is something that can be done with certain types of colostomies to help move stool through the colon. If you have a descending or sigmoid colostomy, you may choose to manage your colostomy with irrigation. Irrigation is simply putting water into the colon through the stoma to help regulate bowel movements.

Colostomy irrigation has been used for many years, but it's not used as much now as years ago. This is probably because pouch systems have improved.

Whether to irrigate is up to each person, but you should fully discuss it with your doctor or ostomy nurse before a decision is made. Your doctor or ostomy nurse will teach you how to irrigate your colostomy. The procedure may be a little different from what we describe here, depending on the experience of the person teaching you.

Talk to your doctor or ostomy nurse about irrigation. Whether you will choose to irrigate your colostomy and how you do it depends on many factors, such as your:

- Lifelong bowel habits
- Activity level

- Skill and comfort level with irrigation
- Personal feelings about the colostomy

If you decide to irrigate, try to find a method, or combination of methods, that most closely matches your body's normal bowel habit or pattern. At first, you may need to try different things under a doctor or nurse's guidance. Just remember, it will take time to set up a routine. Having regular daily habits will help. If you find certain foods or irrigation procedures help regulate your bowel movements, keep doing those things at the same time every day. Regular habits will promote regular bowel functions, but occasional changes in routine won't harm you.

The equipment (Figures 17 to 20) you'll use includes:

- A **plastic irrigating container with a long tube and a cone or tip**. The plastic cone-shaped piece at end of the tubing fits snugly against the stoma to run water into the colostomy.
- An **irrigation sleeve** to carry the irrigation output into the toilet.
- A **tail closure clip** and a belt for extra irrigation sleeve support. (This is optional.)

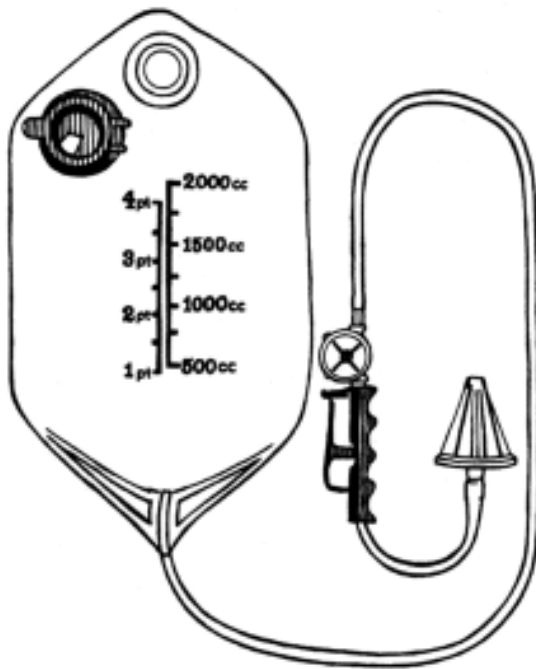
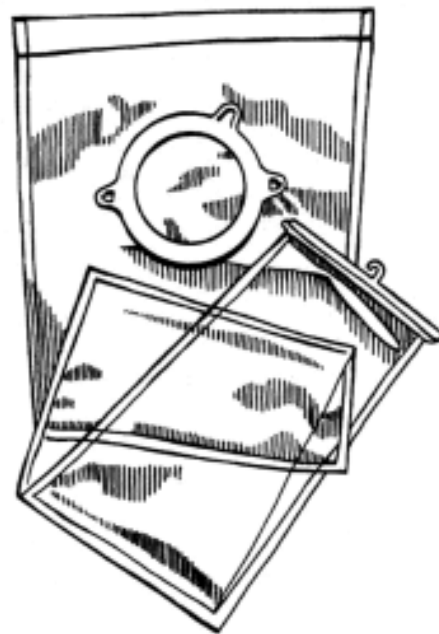


Figure 17
Irrigation System

Figure 18
Irrigation Sleeve



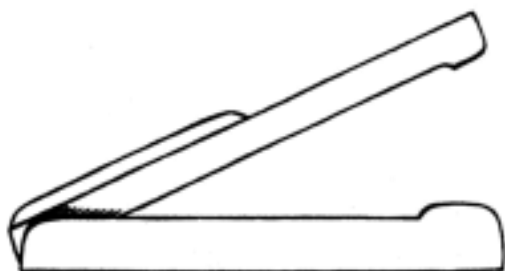
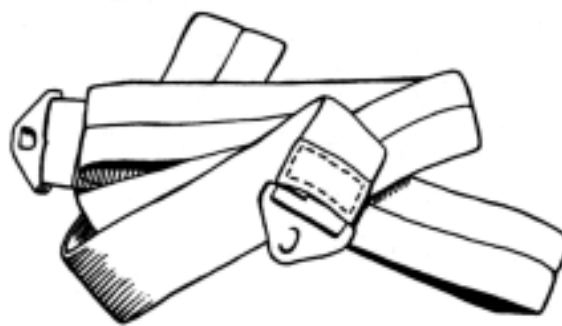


Figure 19
Tail Closure

Figure 20
Adjustable Belt



If you choose to irrigate

When to irrigate

- Choose a time in the day when you know you'll have the bathroom to yourself.
- Irrigation may work better if it's done after a meal or a hot or warm drink. Also, consider irrigating at about the same time of day you usually moved your bowels before you had the colostomy.

How to irrigate

- Get your irrigation supplies together
- Clamp the tubing and put 1000 cc (about 1 quart) of lukewarm (not hot) water in the irrigating container. You may need a little less. NEVER connect the tube directly to the faucet.
- Hang the container at a height that makes the bottom of it level with your shoulder when you are seated.
- Sit on the toilet or on a chair next to it. Sit up straight.

- Seal the plastic irrigation sleeve onto your skin barrier and put the bottom end of the sleeve in the toilet bowl.
- Wet the end of the cone or lubricate it with water-soluble lubricant.
- Remove air bubbles from the tubing by opening the clamp on the tubing and letting a small amount of water run into the sleeve.
- Re-clamp the tubing and put the cone into your stoma as far as it will go, but not beyond its widest point.
- Slowly open the clamp on the tubing and allow the water to gently flow into your bowel. The water must go in slowly. You may shut the clamp or squeeze the tube to slow or stop the water flow. It takes about 5 minutes to drip in 1000 cc (about 1 quart) of water.
- Hold the cone in place for about 10 seconds after all the water has gone in.
- The amount of water you need depends on your own body. You may need less, but do not use more than 1000 cc (1 quart). The purpose of irrigating is to remove stool, not to be strict about the amount of water used.
- You should not have cramps or nausea while the water flows in. These are signs that either the water is running in too fast, you're using too much water, or the water is too cold. After the water has been put in, a bowel movement-type cramp may happen as the stool comes out.
- After the water has run in, remove the cone. Output or "returns" will come in spurts over the next 45 minutes or so.
- As soon as most of the stool has come out, you may clip the bottom of the irrigating sleeve to the top with a tail closure clip. This allows you to move around, bathe, or do anything you wish to pass the time.
- When done, recheck the wafer seal and put your usual pouch back on. Rinse the bag, cone, and sleeve and hang to dry.

With time and experience, you'll know when all the water and stool have come out. A squirt of gas may be a sign that the process is done, or the stoma may look quiet or inactive. If the complete irrigation process always takes much more than an hour, talk to your doctor or ostomy nurse.

Emptying and changing the pouching system

You'll be taught how to change and empty your pouching system before you leave the hospital. You don't have to use sterile supplies. For instance, facial tissue, toilet paper, or paper towels can be used to clean around the stoma instead of sterile gauze pads.

How to empty the pouch

Empty the ostomy pouch when it is about 1/3 to 1/2 full to keep it from bulging and leaking. Follow these steps:

- Sit as far back on the toilet as you can or on a chair facing the toilet.
- Place a small strip of toilet paper in the toilet to decrease splashing.
- Hold the bottom of the pouch up and open the clip on the end or tail of the pouch.
- Slowly unroll the tail over the toilet.
- Gently empty the contents. You can put some toilet paper in the toilet first to help avoid splashing if needed.
- Clean the outside and inside of the pouch tail with toilet paper.
- Roll up the end of the pouch and clip.

When to change the pouching system

It's best to have a regular changing schedule so problems don't develop. Different pouching systems are made to last different lengths of time. Some are changed every day, some every 3 days or so, and some just once a week. It depends on the type of pouch you use.

There may be less bowel activity at certain times in the day. It's easiest to change the pouching system during these times. You may find that early morning before you eat or drink is best. Or allow at least 1 hour after a meal, when digestive movement has slowed down. Right after surgery, ostomy output may be thin and watery. As the output gets thicker, you'll be better able to find the best time for changing your system.

Factors that affect the pouching system seal

The pouching system must stick to your skin. It's important to change it before it loosens or leaks. The length of time a pouch will stay sealed to the skin depends on many things, such as the weather, skin condition, scars, weight changes, diet, activity, body shape near the stoma, and the nature of the ostomy output. Here are some other things that may affect how long a pouch sticks:

- Sweating will shorten the number of days you can wear the pouching system. Body heat, added to outside temperature, will cause skin barriers to loosen more quickly than usual.
- Moist, oily skin may reduce wearing time.

- Weight changes will affect how long you can wear a pouch. Weight gained or lost after ostomy surgery can change the shape of your abdomen. You may need an entirely different system.
- Diet may affect your seal. Foods that cause watery output are more likely to break a seal than a thicker discharge.
- Physical activities may affect wearing time. Swimming, very strenuous sports, or anything that makes you sweat may shorten wear time.

Bathing

Water will not hurt your ostomy. Normal exposure to air or contact with soap and water won't harm the stoma. Water will not flow into the stoma. Soap will not irritate it, but soap may interfere with the skin barrier sticking to the skin. It's best to only use water while cleaning the skin around your stoma. If you do use soap, be sure to rinse your skin well.

If you shower, you can remove your pouch, but it's not necessary and not usually recommended. If you take a bath, it's recommended to leave the pouch in place. One big reason not to remove your pouch when you shower or bathe is to avoid the risk of fecal output happening, which of course you cannot control.

Spots of blood on the stoma

Spots of blood are not a cause for alarm. Cleaning around the stoma as you change the pouch or skin barrier may cause slight bleeding. The blood vessels in the tissues of the stoma are very delicate at the surface and are easily disturbed. The bleeding will usually stop quickly. If it doesn't, call your ostomy nurse or your doctor.

Shaving hair under the pouch

Having a lot of hair around the stoma can make it hard to get the skin barrier to stick well and may cause pain when you remove it. Shaving with a razor or trimming hair with scissors is helpful. Extra care should always be taken when doing this. It's recommended that you dry shave the skin around your stoma with stoma powder, since soap and shaving creams have lotions and oils that may cause the skin barrier not to stick. After shaving, rinse well and dry the skin well before applying your pouch.

What to wear when you have a colostomy

You will not need special clothes for everyday wear. Ostomy pouches, especially certain kinds, are fairly flat and hard to see under most clothing. The pressure of elastic undergarments won't harm the stoma or prevent bowel function.

If you were sick before surgery, you may find you can now eat normally for the first time in years. As your appetite returns, you may gain weight. This can affect the clothes you choose more than the pouching system itself.

Snug undergarments such as cotton stretch underpants, t-shirts, or camisoles may give you extra support, security, and help conceal pouches. A simple pouch cover adds comfort by absorbing body sweat and keeps the plastic pouch from resting against your skin. Men can wear either boxer or jockey-type shorts.

Managing colostomy problems

Gas (flatulence)

Right after surgery it may seem that you have a lot of gas almost all the time. Most abdominal surgery is followed by this uncomfortable, embarrassing, yet harmless symptom. Gassy noises or stomach rumblings may be a concern. If you are concerned about others nearby hearing this, you can say, "Excuse me, my stomach's growling." If you feel as though you are about to release gas when you're with people, casually fold your arms across your belly so that your forearm rests over your stoma. This will muffle most sounds. Check with your ostomy nurse about products you can take to help lessen gas. Certain foods may cause gas, such as eggs, cabbage, broccoli, onions, fish, beans, milk, cheese, carbonated drinks, and alcohol.

- Eating regularly will help prevent gas.
- Eat smaller amounts of food 4 to 5 times a day.
- **DO NOT** skip meals to avoid gas or output.

Odor

Many factors, such as foods, normal bacteria in your intestine, illness, certain medicines, and vitamins can cause odor.

- Some foods can produce odor: eggs, cabbage, cheese, cucumber, onion, garlic, fish, dairy foods, and coffee are among them. If you find that certain foods bother you, avoid them.

- Use an odor-resistant pouch.
- Check to see that the skin barrier is stuck securely to your skin.
- Empty the pouch often.
- Place special deodorant liquids and/or tablets in the pouch.
- There are some medicines you can take that may help. Check with your doctor or ostomy nurse about these products and how to use them. Some things that many people have found help with odor are chlorophyll tablets, bismuth subgallate, and bismuth subcarbonate. Keeping air deodorizers in that room can also control odor very well when you are emptying the pouch

Finding medicine capsules in your pouch

Be aware that coated tablets or time-released capsules may come out whole in the pouch. In most cases, this means you didn't get the medicine. If you notice this, talk with your health care provider or pharmacist. There may be other medicines you can use to make sure you're getting what you need. Liquid or liquid gel medicines tend to absorb faster and may work better for you.

Severe skin problems

Large areas of skin that are red, sore, and weeping (always wet) will keep you from getting a good seal around your stoma. It's important to treat minor irritations right away. If you have a large irritated area, or one that's getting larger despite special care, contact your doctor or ostomy nurse. They may prescribe medicine to take by mouth or to put around your ostomy to help dry out and heal your skin.

For deep pressure ulcers caused by a very tight ostomy belt, loosen or remove the belt and call your doctor or ostomy nurse right away. You will need treatment.

Blockage (obstruction)

There will be times when your ostomy does not have output for short periods of time. This is normal. But, if your stoma is not active for 4 to 6 hours and you have cramps, pain, and/or nausea, the intestine could be blocked (the medical word is *obstructed*). Call your doctor or ostomy nurse right away if this happens.

These are some things you can do to help move things through your ostomy:

- Watch for swelling of the stoma and adjust the opening of the wafer as needed until

the swelling goes down.

- Take a warm bath to relax your abdominal muscles.
- Fluids can be taken if there is some stool output: solid foods should be avoided
- Sometimes changing your position, such as drawing your knees up to your chest, may help move along the food in your gut.
- Do **NOT** take a laxative.

Foods high in fiber such as cabbage, greens, celery, pineapple, nuts, coconut, and corn can cause obstruction. Obstruction can also be caused by internal changes such as adhesions (scar tissue that forms inside your abdomen after surgery).

If you keep having pain and cramping with no output from your stoma for more than 2 hours, and you can't reach your doctor or ostomy nurse, go to the emergency room. Take all your ostomy supplies with you.

Diarrhea

Diarrhea is usually a warning that something isn't right. Diarrhea is defined as frequent loose or watery bowel movements in greater amounts than usual. It happens when food passes through the small intestine too quickly for fluids and electrolytes to be absorbed. It can come on suddenly and may cause cramps. It can cause your body to lose a lot of fluids and electrolytes. You must quickly replace these electrolytes to avoid getting sick from dehydration and mineral loss. (See Electrolyte imbalance below for more on this.)

Loose stool can also come from eating certain foods, but it usually only lasts a short time. Raw fruits and vegetables, milk, fruit juice, prune juice, or impure drinking water are examples of things that may change your stoma output. Emotional stress may also cause loose stool. Some people with ileostomies may always have "watery discharge," and this is normal for them.

Several things can cause diarrhea:

- Intestinal infection or food poisoning, which may also cause fever and/or vomiting
- Antibiotics and other prescription medicines
- Partial blockage, which also causes smelly discharge, cramps, forceful liquid output, and a lot of noises from the stoma. It can be caused by food or other factors. Get medical help if this happens to you.

Talk with your doctor or ostomy nurse if you have ongoing diarrhea. Discuss the foods and liquids you take in, your eating schedule, how much you usually eat, and any

medicines you might be taking. You may be given medicine to help slow things down. Remember, no matter what, you need a well-balanced diet and good fluid intake to have a good output.

Electrolyte imbalance

Electrolytes are salts and minerals in the blood, like potassium, magnesium, and sodium. Keeping them balanced is important. When the colon (large intestine) is removed, you're at a greater risk for electrolyte imbalance. Diarrhea, vomiting, and a lot of sweating can increase this risk.

Dehydration is also a serious concern. Symptoms include increased thirst, dry mouth, decreased urine output, feeling light-headed, and feeling tired. If you get dehydrated, you'll need to drink more fluids. To avoid dehydration, you should try to drink 8 to 10 eight-ounce glasses of fluid a day. If you have diarrhea, you may need more. Drinks such as Gatorade[®], PowerAde[®], or Pedialyte[®] contain potassium and sodium. But any liquid containing water (soda, milk, juice, tea, etc.) helps to meet your daily need for fluid.

Loss of appetite, drowsiness, and leg cramps may be signs of sodium loss. Fatigue, muscle weakness, and shortness of breath may be signs of potassium loss. Dehydration, low sodium, and low potassium can all be dangerous and should be treated right away. Keep in mind that some of these symptoms can be caused by other problems which may be emergencies. Call your doctor or 911 right away if you are dizzy, weak, or having other serious symptoms.

Phantom rectum

Phantom rectum is much like the "phantom limb" of amputees who feel as if their removed limb is still there. It's normal for you to have the urge to move your bowels the way you did before surgery. This can happen at any time and may go on for years after surgery. If the rectum has not been removed, you may have this feeling and also may pass mucus when sitting on the toilet. Some people who have had their rectum removed say that the feeling is helped by sitting on the toilet and acting as if a bowel movement is taking place.

Short bowel syndrome

This condition happens when surgery is done to remove a large part of the small intestine. Short bowel syndrome needs special attention because there's not enough intestine left to absorb the nutrients the body needs.

People with short bowel syndrome must be under a doctor's care. They must be closely watched to make sure they're taking in enough calories, carbohydrates, proteins, fats, vitamins, and minerals. They can live a normal life, but must be careful to avoid diarrhea, and be within quick reach of medical care. The shorter the small intestine, the more watery the discharge will be. This may reduce the time a pouch can be worn because the skin barrier breaks down more rapidly.

When you should call the doctor

You should call the doctor or ostomy nurse if you have:

- Cramps lasting more than 2 or 3 hours
- Continuous nausea and vomiting
- No ostomy output for 4 to 6 hours with cramping and nausea
- Severe watery discharge lasting more than 5 or 6 hours
- Bad odor lasting more than a week (This may be a sign of infection.)
- A cut in the stoma
- Injury to the stoma
- Bad skin irritation or deep sores (ulcers)
- A lot of bleeding from the stoma opening (or a moderate amount in the pouch that you notice several times when emptying it) (NOTE: Eating beets will cause some red discoloration.)
- Continuous bleeding where the stoma meets the skin
- Unusual change in your stoma size or color
- Anything unusual going on with your ostomy

Ordering and storing ostomy supplies

Supplies may be ordered from a mail order company, from a medical supply store, a local pharmacy, or online. For additional help ordering, try contacting the product manufacturer, check your local phone book's business pages, or check the Internet (try searching for "ostomy supplies").

- To order pouches, skin barriers, and other ostomy products, you'll need both the **manufacturer's name and the product numbers**.
- Talk with your ostomy nurse about reputable dealers who can supply you with what you need.
- Before ordering your supplies, check with your health insurance to be sure that they

work with the company in question.

- Compare prices when using mail order and the Internet (remember to include shipping costs).
- Keep all your supplies together on a shelf, in a drawer, or in a box in a dry area away from moisture and hot or cold temperatures.
- Order supplies a few weeks before you expect them to run out to allow enough time for delivery. DO NOT stockpile supplies – they can be ruined by moisture and temperature changes.

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