For nearly 75 years, colostomy irrigation has been an accepted management option that allows a colostomy patient to control bowel evacuation. Colostomy irrigation evolved as an answer to the nearly universally chronic peristomal skin problems caused by a lack of commercially available pouching systems, protective skin barriers, and skin care products. It was theorized that if the bowel could be evacuated once a day, no stool would seep onto the skin and, therefore, peristomal skin irritation would be minimized. Since that time, however, the procedure has gone in and out of acceptance by both patients and professionals—mostly due to fear of bowel perforation from irrigation catheters. This fear has been reversed by the introduction of soft catheter irrigation cones now available on most colostomy irrigation sets. For many years, nearly all colostomy patients were instructed on colostomy irrigation, but the outcomes were often less than satisfactory for the patient. Today, more realistic criteria have been developed to screen for those patients who have a better chance of success with it. Even though colostomy irrigation is not required to maintain bowel function, the procedure is a management option that may allow a patient to be free from fecal discharge for approximately 24 hours. The most important factors to evaluate in determining who is a candidate for colostomy irrigation are the patient’s clinical situation and lifestyle. For example, a patient with a sigmoid colostomy who has good manual dexterity and visual acuity, had regular bowel habits prior to surgery, is not undergoing chemotherapy, and is not taking medications that cause diarrhea may appear to be a perfect candidate. However, an assessment of the patient’s lifestyle reveals that he works “swing-shift” hours and has an irregular work schedule. It would be nearly impossible for this patient to attempt colostomy irrigation at a regular time each day. Similarly, a physician writes orders for the home care nurse to teach a new patient how to irrigate. The initial home visit reveals that the patient lives in a setting without adequate bathroom facilities and running water. A patient’s inability to obtain control over bowel function in the manner prescribed by healthcare professionals can lead to feelings of frustration and failure, which decreases the overall quality of the patient’s life.

A small prospective, crossover study in Singapore compared natural evacuation (ie, allowing the bowel to function on its own) to colostomy irrigation and found that colostomy irrigation after abdominoperineal resection was superior to natural evacuation in terms of cost and patient satisfaction. When patients irrigated, fewer peristomal skin problems, sleep disturbances, and sexual problems occurred. An overall decrease in management costs also was demonstrated due to a decrease in pouch usage. The study’s researchers recommended that colostomy irrigation be introduced to qualified patients soon after surgery.

In an outcomes-oriented environment, clinicians should evaluate each patient on a case-by-case basis to determine if the patient can benefit from colostomy irrigation. Below are some criteria to consider during this assessment. Candidates should have:

- a descending or sigmoid colostomy
- a history of regular bowel habits prior to surgery
- the desire to learn and perform the procedure
- the ability (manual dexterity and visual acuity) to perform the procedure
- a lifestyle that is compatible to irrigation (work schedule, bathroom facilities, adequate time, other family or personal issues).

Patients with stomal prolapse or peristomal hernia should not be taught colostomy irrigation because performing the procedure could potentially exacerbate the
prolapse or cause bowel perforation, leakage between irrigations, or poor control over elimination. Chemotherapy, pelvic or abdominal radiation treatments, a poor prognosis, and diarrhea-producing medication are also contraindications to colostomy irrigation. Age, on the other hand, should not be considered a contraindication, as colostomy irrigation has been shown to be effective regardless of the person’s age. Therefore, each individual should be carefully evaluated as a candidate.

Once taught, the patient always has the choice to discontinue the procedure should it become incompatible with his or her lifestyle. The opportunity to learn the procedure exists for candidate patients throughout the duration of their treatment within the healthcare system (ie, home health care, outpatient clinic, doctor’s office, WOC nurse clinic).

Colostomy irrigation is not the solution for all colostomy patients, but the decision to irrigate or not irrigate is ultimately the patient’s — not the healthcare professional’s. - OWN

References

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Gwen B. Turnbull, RN, BS, author of The Ostomy Files, is a healthcare consultant specializing in public and private healthcare reimbursement as well as the development of professional and consumer educational and marketing tools.

Ostomy/Wound Management

Accuzyme®
Papain-Urea Debriding Ointment

DESCRIPTION: Papain-Urea Debriding Ointment contains papain (1.3 X 10^15 USP units of activity based on Lot 121 and 131) and urea (1% w/v) in a hydrophilic base composed of polyethylene glycol 400 (PEG 400), glycerin, USP, propylene glycol, USP, and purified water (USP). The activator of papain (urea) is combined with a preservative, a dermatologically harmless, to bring about two supplementary chemical actions: (1) to expose and solubilize the activators of papain, and (2) to denature the nonviable protein matter in lesions and thereby render it more susceptible to enzymatic digestion. The stability and shelf-life of Accuzyme® is maintained by adding an appropriate pH of 6.5 to 8.0. All Accuzyme® products are manufactured in a cGMP facility. Accuzyme® is not made with animal products. Accuzyme® is supplied in a 30g tube for use under pressure dressings.

INDICATIONS AND USES: Accuzyme® is indicated for debridement of necrotic tissue and superficial non-contaminated acute and chronic lesions such as pressure sores, varicose and diabetic ulcers, trochanteric bursitis, surgical wounds, dorsal foot ulcers, venous ulcers, and skin ulcers caused by ischemia.

CONTRAINDICATIONS: Accuzyme® is contraindicated in patients who have shown sensitivity to papain or any other components of this preparation.

PRECAUTIONS: See Dosage and Administration. Not to be used in the eye.

ADVERSE REACTIONS: Accuzyme® is generally well-tolerated and, when used according to directions, is considered a harmless agent. Occasionally, the profuse exudate from enzymatic digestion may cause an allergic “burning” sensation, which may be experienced by a small percentage of patients upon applying Accuzyme®. Occasionally, the preferential enzyme papain exudates may irritate the skin. In such cases, more frequent redressings will alleviate discomfort until readings decrease.

HOW SUPPLIED: 30g tube, 6g unit dose tube. Store at controlled room temperature (59°-86°F, 15°-30°C).

Panafil Healing, Debriding and Deodorizing Ointment

Papain-Urea-Chlorophyllin Copper Complex Salve

DESCRIPTION: Panafil Healing, Debriding and Deodorizing Ointment contains Papain, Chlorophyllin Copper Complex Salve (0.1%, w/v), and Urea (10%, w/v) in a hydrophilic base composed of Polyethylene Glycol, USP, Propylene Glycol, USP, White Petrolatum, USP, Sorbitan Oleate, USP, Polysorbate 60, USP, Sodium Hydroxide, USP, Bicarbonate, USP, Sterile Water for Injection, USP, and Fragrance.

CLINICAL PHARMACOLOGY: Papain, the proteolytic enzyme derived from the fruit of carica papaya, is a patient digestate of viable protein matter, but it is harmless to viable tissue. It has the unique advantage of being active over a wide pH range, 3 to 12. Despite its inertial activity as a digestive agent, papain is relatively ineffective when used alone as a debriding agent, presently because it requires the presence of activators to exert its digestive function. Urea is combined with papain to provide two supplementary chemical actions: (1) to expose and solubilize the activators of papain (thiol groups) which are always present, but not necessarily accessible, in the nonviable tissue or debris of lesions, and (2) to denature the nonviable protein matter in lesions and thereby render it more susceptible to enzymatic digestion. Enzymatic and pharmacological studies show that the combination of papain and urea produces twice as much degradation as papain alone.

Panafil Healing, Debriding and Deodorizing Ointment is made with Pharmalyte, a wound healing agent designed to promote re-epithelialization in burns and related wounds. Early studies indicate that healing, debridement, and deodorization occur concomitantly when Pharmalyte is used. In vitro studies also show that Pharmalyte enhances the delivery and utilization of the other active ingredients in Panafil Healing, Debriding and Deodorizing Ointment. Pharmalyte contains the following: (1) an active ingredient that promotes a moist wound healing environment and facilitates the delivery of other wound healing ingredients, and (2) a combination of ingredients that promotes an active wound healing environment.

HOW SUPPLIED: 30g tube, 6g unit dose tube. Store at controlled room temperature (50°-84°F, 10°-29°C).

References