



Enteroatmospheric Fistula in the large fungating wound and Enterocutaneous Fistula

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Background

A fistula is an abnormal epithelialized connection between two bodies with intestinal tract and skin. The effluent from intestinal tract is contain proteolytic digestive enzymes (Hoedema,R.E.& Suryadevara S.,2010) as a fungating wound is often produce excessive exudate. The effect of continuous moisture from effluent and exudate are skin damage. A suitable care with these situation are skin prevention. The problem of Enteratmospheric Fistula (EAF), Enterocutaneous Fistula (ECF) and fungating wound are malodor, bleeding, risk for skin irritation from excessive effluent and exudate which difficult to control including patient discomfort. The principles of wound care are vital importance.

Methods:

A 67-year-old male diagnosed advance CA Sigmoid colon S/P Exploratory laparotomy for tumor removal with biopsy. Improve nutritional status by TPN via central line. One month post operation, EAF developed in a large fungating wound. Two months later, the ECF developed at 2 centimeters above fungating wound.



Figure 1 Enteroatmospheric Fistula in the large fungating wound

Intervention procedures

The goals of management were control odor, collect effluent and exudate, protecting perifistula and periwound skin. The management of Enteroatmospheric Fistula in the large fungating wound and Enterocutaneous Fistula Intervention procedures are mentioned below. (Figure 2)

1. Irrigated with normal saline solution on fungating wound by non-forceful technique.
2. Protected peri-fistula skin with skin barrier film, managing skin lesion with skin barrier powder and contoured peri-fistula with skin barrier paste.
3. Used pouching system at EAF in fungating wound and ECF with one piece flexible drainable pouch by saddlebagging technique. (Bryant RA.& Rolstad BS.,2012)



Figure 2 Intervention procedures by pouching system with saddlebagging technique

Eight months later, he received radiation and chemotherapy. The size of both fistula and large fungating wound were reduced. Twelve months later, ECF healed, the effluent from EAF was reduced and fungating wound was smaller. Therefore change management by hydrofiber foam. (Figure 3)



Figure 3 Intervention procedures by hydrofiber foam.

Results

One year later, EAF and fungating wound were improved, ECF was closed. Finally, the patient underwent surgery for closed EAF. The quality of life was improved. (Figure 4)

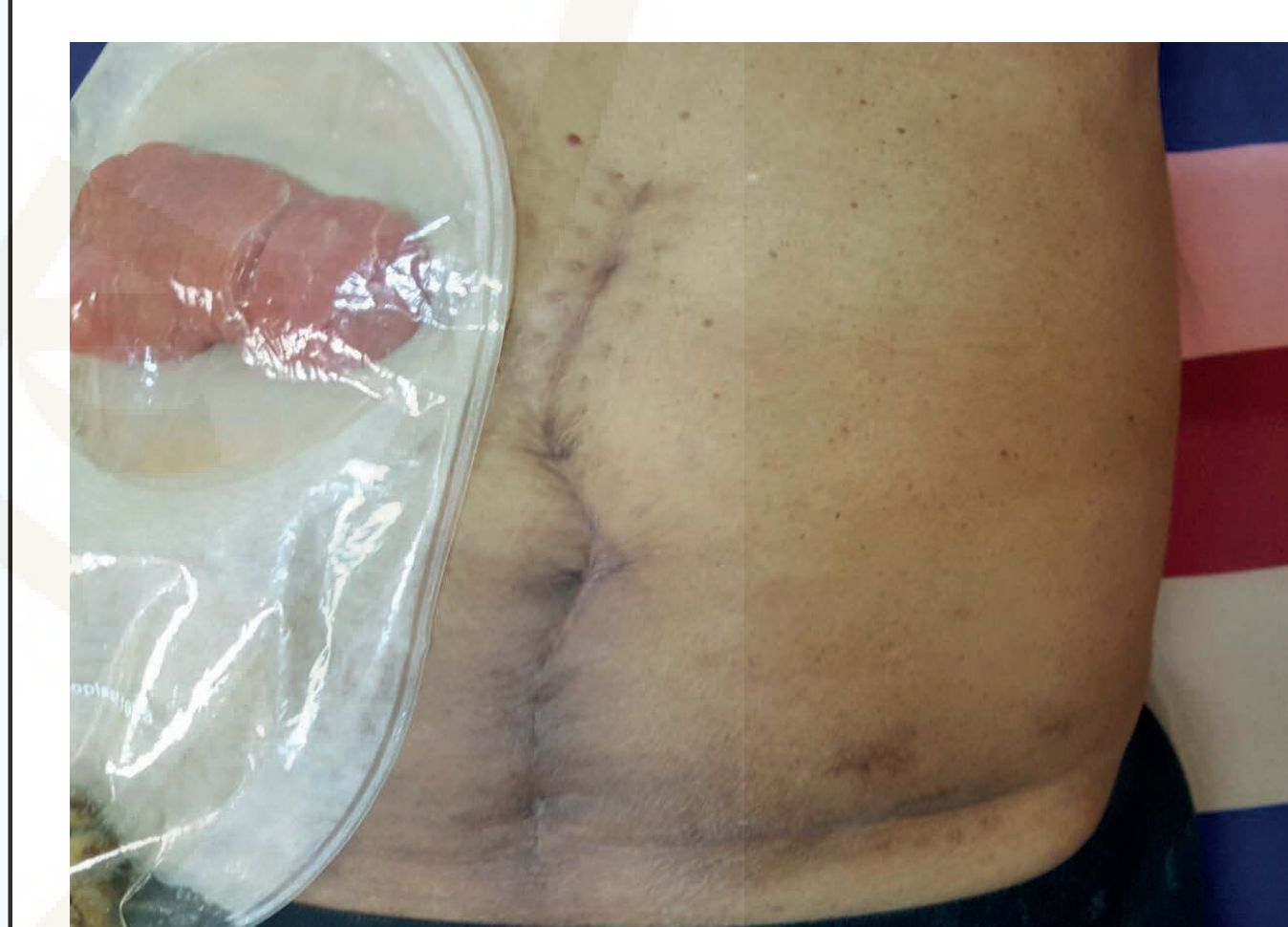


Figure 4 One year after treatment

Conclusion

The challenge to management of fistula and fungating wound with art and science for caring. Moreover a concurrent treatment is important to enhancing patient comfort and improves quality of life.

Reference

- Bryant RA., & Rolstad BS. (2012).Management of Draining Wounds and Fistulas.Acute & Chronic Wounds Current Management Concept.4thed.United State of America: 2012; 529.
- Hoedema, R. E., & Suryadevara, S. (2010). Enterostomal therapy and wound care of the enterocutaneous fistula patient. Clinics in colon and rectal surgery, 23(3), 161–168.