



# Clinical Challenge: The Severe Mucocutaneous Separation

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## Abstract

A mucocutaneous separate occurs when a stoma detachment from the peristomal skin. It can be superficial or depth and partial or circumferential. The goal of management in this case was to treat infection, reduce the patient's pain and discomfort, support nutrition, collect effluent, treat mucocutaneous line separation and debride necrotic tissue. The Severe Mucocutaneous Separation management was effectively to pouching and wound management.

**Keywords:** Mucocutaneous separate

## Introduction

A mucocutaneous separate occurs when a stoma detachment from the peristomal skin. It can be superficial or depth and partial or circumferential. Mucocutaneous Separation results from problem with surgical stoma construction. Include creating on oversized opening in the skin when forming the stoma or excessive tension on the suture line. As a secondary complication of retraction or necrosis and sequel of poor healing from a disease process. Mucocutaneous separate occurs more commonly in the immunocompromised, patient relate to the malnutrition, corticosteroid therapy, diabetic, post-radiation therapy and infection. The patient may complain of pain or burning.<sup>1, 2</sup>

## Case report

This case study reports on a 69 years-old Thai female, known case locally advanced CA rectum. Present with Lower Gastrointestinal Bleeding 2 month ago. She had lower abdominal pain and feces bloody. CT whole abdomen shown CA middle rectum with multiple regional lymph node and colonoscopy is half circumferential ulcerative mass 5-6 cm from Anal Verge. Pathology was Moderate differential adenocarcinoma. Patient started Neoadjuvant CCRT complete and then, who has undergone Hand-assisted laparoscopic low anterior resection with Hartmann's procedure. Post-operative Days 10, Colostomy was slightly protruding, had necrotic tissue approximately width 1.5 cms at mucocutaneous suture line around stoma and circumferential mucocutaneous separated, depth 2 cms at 4-6 O'clock but that did not perforate through sheath, signs of infection shown with fever and peristomal skin erythema. The patient's pain score 10. Enterostomal therapist nurse was consulted and established goals for pouching and wound healing. The Integrated medical and nursing approach for proper management. The goal of management was to treat infection, reduce the patient's pain and discomfort, support nutrition, collect effluent, treat mucocutaneous suture line separation and debride necrotic tissue.

## Clinical assessment

First assessment: end sigmoid colostomy at left lower quadrant, round shape size 23 mm, red moist and slightly protruding, opening of lumen at apex, peristomal skin erosive lesion around 25% yellow liquid effluent and mucocutaneous suture line separate.

- 3 O'clock wide 1.5 cm.
- 5 O'clock wide 1.5 cm.
- 6 O'clock wide 1.5 cm.
- 9 O'clock wide 1.5 cm.
- 12 O'clock wide 1.5 cm.
- 4-6 O'clock depth 2 cm.



Figure 1 Mucocutaneous suture line separate

## Nursing Intervention

procedure for this case are mentioned by

1. Cleaned stoma with NSS and used irrigation technique at separate area.
2. Applied skin barrier film at peristomal skin for protecting skin around stoma from effluent.
3. Used Hydrofiber Ag fill in depth separation area.
4. Applied skin barrier powder and skin barrier paste shallow separation area.
5. Used one piece system for pouching.

Post operative 3 weeks used convexity two-pieces system because stoma was flush



Figure 2

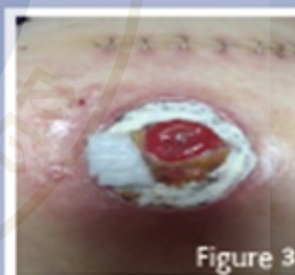


Figure 3



Figure 4

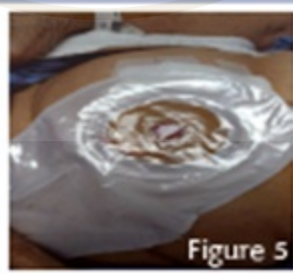


Figure 5

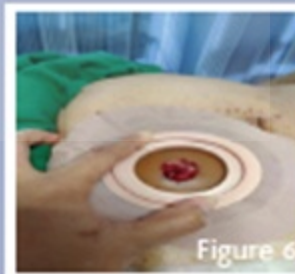


Figure 6



Figure 7

Figure 2-7 Nursing intervention procedure

## Result

About 4 weeks after starting intervention the mucocutaneous separate was heal.

## Conclusion

The severe mucocutaneous separation management in this case was effectively to pouching and wound management. As a result, the frequency of pouching change was reduced and patient feel comfortable, wound healing and quality of life were improved.

## Reference

1. Karen Z. Ostomy terms and definition-continued. WCET J 2015; 35(3):48-50.
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