



Management of enterocutaneous fistula with abdominal wound dehiscence.

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Introduction

The small intestine is quite radiosensitive and is potentially in the treatment for intra-abdominal, retroperitoneal and pelvic tumors. Chronic bowel injury is caused by submucosal obliterative vasculitis that results in further ischemia and fibrosis. Fibrotic strictures may cause small bowel obstruction¹. Stoma creation for treatment of intestinal obstruction in patient with excessive tension of intestine may have many postoperative complication such as stoma retraction², mucocutaneous suture line separation and then the effluent cannot drain to stoma pouch, that cause of enterocutaneous fistula to abdominal wound. Enterocutaneous fistula with abdominal wound dehiscence is a complex complication and present a challenge to enterostomal therapist nurse (ETN) for effective pouching, peristomal skin care and local wound care.

Case report

This case study reports on a 59 year old female underlying disease HT. Know case CA Cervix post radiation therapy 11 years ago. CT abdomen show complete colonic obstruction and she went to explore laboratory with ileocaecostomy with double barrel colostomy. Opening of proximal lumen was below skin level, mucocutaneous suture line was separate and she got fistula from stoma to wound dehiscence (figure1). Enterostomal therapist nurse was consulted and established goals for stoma pouching and wound management which included: Peristomal skin protection, pouching and accurate measurement of effluent, control infection and promote wound healing, enhanced patient comfort and odor control, optimized patient satisfaction and quality of life.

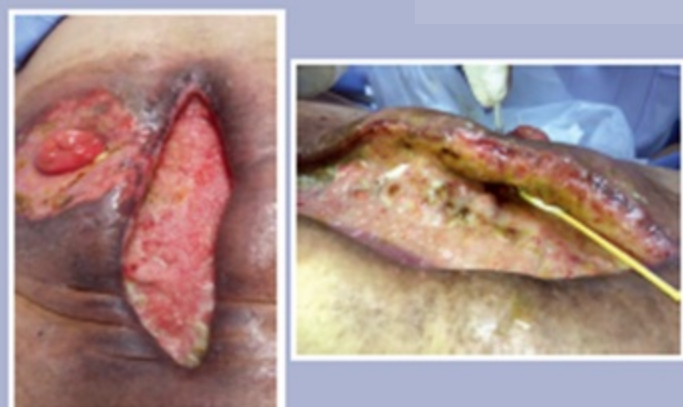


Figure 1.

Left ; Wound dehiscence and opening of proximal lumen was below skin level.

Right ; Fistula from proximal lumen of stoma to wound dehiscence.

The Intervention

(1) Stoma care : clean with tap water, protect peristomal skin with stomahesive powder and skin barrier film, contouring peristomal skin with stomahesive paste, suction tube was place at opening of lumen and pouching with transparent one piece drainable pouch (figure 2).



Figure 2 Stoma care and pouching technique.

(2) Local wound care : clean with 0.9% NSS (swabbing technique and non force full irrigation technique). Protect surrounding skin with skin barrier film. Separation technique used skin barrier paste and skin barrier strip paste create bridge between double barrel colostomy and dehiscence wound. Promoted granulation tissue at dehiscence wound with Collagen gel³, controlled exudate and infection with hydrofiber Ag. (Figure3).



Figure 3 Local wound care.

Conclusion

The enterocutaneous fistula within abdominal wound dehiscence management in the case study was effectively to pouching and odor management. As a result, the frequency of pouching change were reduced and dehiscence wound healed in 7 month, patient comfort and quality of life were improve. (figure4).



Figure 4 wound was healing in 7 month after intervention.

Reference

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