ABSTRACT
This article provides an executive summary of the recommendations from the Clinical Guideline: Management of the Adult Patient With a Fecal or Urinary Ostomy, published by the Wound, Ostomy and Continence Nurses Society (WOCN Society). It presents an overview of the process used to update and develop the guideline and lists specific recommendations from the guideline. We provide recommendations that include the following topics: stoma construction, preoperative education, stoma site marking, selection of an ostomy pouching system, postoperative education, postoperative management issues, follow-up care after discharge from the acute care setting, health-related quality of life, and stomal and peristomal complications. The intent of the guideline is to provide information that will assist healthcare providers to manage adult patients with ostomies, prevent or decrease complications, and improve patient outcomes. The full text of the published guideline, which includes available evidence supporting the recommendations and a complete reference list, is available in print and as a mobile application from the WOCN Society’s online bookstore (http://www.wocn.org). Refer to Supplemental Digital Content 1 (available at: http://links.lww.com/JWOCN/A40) associated with this article for a complete reference list for the guideline.

KEY WORDS: Clinical guideline, Colostomy, Ileal conduit, Ileoostomy, Ostomy, Ostomy pouching system, Peristomal, Quality of life, Stoma, Urostomy.

INTRODUCTION
More than 700,000 Americans have had ostomy surgery! An ostomy is a surgically created opening for the elimination of stool or urine that can be temporary or permanent. Most stomas require the use of a pouching system. A pouching system consists of an adhesive and solid skin barrier that fits around the stoma and an odor-proof pouch to collect stool or urine. The purpose of the pouching system is to maintain peristomal skin health, provide a secure and predictable seal, and allow the person with an ostomy to engage in activities of daily living.

An individual undergoing ostomy surgery, whether temporary or permanent, faces multiple challenges and lifestyle changes. Preoperative and postoperative education and follow-up care are essential to ensure optimal outcomes for the individual. New skills must be achieved while the individual is adjusting to body image changes and adapting to new circumstances.
The most common types of ostomies are ileostomies, colostomies, and ileal conduits (often referred to as urostomies). The indications for creation of an ostomy include cancer of the colon or rectum, bladder cancer, nonmalignant conditions such as inflammatory bowel disease (ulcerative colitis, Crohn's disease), trauma, congenital disorders such as Hirschsprung's disease or imperforate anus, familial adenomatous polyposis, diverticular disease, and severe neurogenic bladder dysfunction not manageable by more conservative means.

Surgical techniques have evolved, and techniques utilizing laparoscopic and robotic-assisted surgery approaches to create stomas are becoming more common. These newer techniques decrease hospital length of stays, postoperative pain, and ileus. However, ostomy surgery continues to have high rates of surgical complications compared to other common surgical procedures. The unadjusted morbidity rate for ostomy surgery has been reported at 42.9%, with a mortality rate of 10.7%. Ostomy complications may be categorized as stomal or peristomal. Stomal complications include mucocutaneous separation, stoma retraction, stenosis, necrosis, prolapse, fistula, trauma, and peristomal hernia. Peristomal complications include peristomal moisture-associated skin damage, allergic contact dermatitis, mechanical injury, fungal/candidiasis infection, varices, folliculitis, pyoderma gangrenosum (PG), hyperplasia, and suture granulomas. Many of these problems are related to construction and placement of the stoma or inappropriate use of the pouching system.

Preoperative marking of the stoma site is associated with reduced postoperative complications; fewer problems with fitting and management of the ostomy pouching system, and an improved health-related quality of life (HRQOL) and independence. Therefore, best practices for the care of individuals with an ostomy or undergoing an ostomy include preoperative siting of the stoma, early identification of stomal and peristomal problems, and timely interventions directed at the cause of the problems.

Postoperative ostomy education is as important as preoperative education. Ideally, before hospital discharge, the patient can manage all aspects of stoma care independently. Patients have identified that education that promotes self-care and activities of daily living should be the focus of teaching prior to hospital discharge. However, the increased use of advanced surgical techniques and shorter hospital stays due to enhanced recovery after surgery protocols/pathways have decreased the amount of time in the hospital for providing patient education and for the patient to learn the basic self-care skills for management of the ostomy.

Most patients with ostomies will experience some long-term and perhaps lifelong needs after discharge. They include concerns or issues related to stoma location, daily self-care of the ostomy, pouch and adhesive problems, leakage, odor, skin irritation, diet, clothing, family awareness and acceptance of the ostomy, activity limitations, and the impact of the ostomy on health-related quality of life.

Ostomy specialists such as wound, ostomy, and/or continence (WOC) nurses are essential for preoperative and postoperative education of patients undergoing ostomy surgery, including long-term access to the specialist for problems. According to the 2015 Clinical Practice Guidelines for Ostomy Surgery by the American Society of Colon and Rectal Surgeons, all patients who have ostomies should have access to an ostomy nurse for follow-up care, as needed and wherever possible. Therefore, follow-up care after discharge by home healthcare services, a home-health WOC nurse, or by an ostomy nurse in an outpatient care/clinic setting is highly recommended. In addition, to facilitate adaptation of the person living with a stoma, coordination of care is required across healthcare settings and among all disciplines that provide care to the person with an ostomy.

This article provides an executive summary of the recommendations from the Clinical Guideline: Management of the Adult Patient With a Fecal or Urinary Ostomy, published by the Wound, Ostomy and Continence Nurses Society (WOCN Society). This executive summary provides an overview of the process used to update and develop the guideline and lists specific recommendations from the guideline. The intent of the guideline is to provide information that will assist healthcare providers to manage adult patients with ostomies, prevent or decrease complications, and improve patient outcomes. The full text of the published guideline, which includes the available evidence supporting the recommendations and a complete reference list, is available in print and as a mobile application from the WOCN Society’s online bookstore (http://www.wocn.org). Refer to Supplemental Digital Content 1 (available at: http://links.lww.com/JWOCN/A40) associated with this article for a complete reference list for the guideline.

**GUIDELINE DEVELOPMENT**

In 2014, the WOCN Society established a task force to update the 2010 Management of the Patient With a Fecal Ostomy: Best Practice Guideline for Clinicians. The task force included 7 certified wound, ostomy, and continence nurses (CWOCNs) from the Society’s membership who represented a wide range of experience and clinical practice backgrounds, a representative of the United Ostomy Associations of America, and 4 consulting surgeons (colorectal, urology). All task force members completed a Disclosure Form and were screened for any potential conflicts of interest in regard to the topic or development of the guideline. One task force member was an employee of Hollister Incorporated; however, Hollister had no input into the clinical content of the guideline.

A topical outline was designed for the guideline. Seventeen questions were developed by the task force to guide the literature review and search for evidence about the following topics: types of ostomies, education, stoma site marking, pouching options and basic management, stomal and peristomal complications and interventions, and quality of life (Table 1).

**IDENTIFYING THE EVIDENCE**

**Search Strategy**

The guideline development task force utilized 2 professional librarians from Daemen College to conduct the literature search. The Daemen College library utilizes the EBSCO Discovery Service, a robust metadata program, which obtains materials from major journal publishers and other information providers. The librarians’ searches were conducted July through September 2014. In addition, because the project was still in process in the spring of 2015, all searches were updated in March and May 2015. The searches were limited to academic and scholarly, peer-reviewed journals. The searches included literature that was published from 2009 to 2015 for the combined search terms of “ileostomy and colostomy” and from 1999 to 2015 for “urostomy” terms. Included in the
review were studies reporting primary data regarding types of ostomies, care and management of ostomies, and therapies.

The results of the literature search were distributed to the guideline task force for review. Using predetermined inclusion and exclusion criteria (Table 2), the titles and abstracts were screened, and where congruent with the inclusion criteria, full publications were obtained for review. In total, 188 papers met the criteria for review, 62 papers were excluded, and 126 papers were included in the guideline.

Rating of Research Evidence
The questions to guide the literature review were divided among the task force members, and each reviewer read and summarized the articles related to their topics/questions. Each article was assigned a level-of-evidence rating (level I to level VI) using the established criteria identified in Table 3.

Synthesis and Evaluation of the Evidence
After the individual members of the task force reviewed selected studies, a written summary of the evidence was presented to all members of the task force for review, discussion, and clarification. The summary included the article title, author, journal, methods, participants, and outcomes/conclusions. A series of conference calls was conducted during 2015 and 2016, and the guideline was finalized incorporating evidence from the studies.

Level-of-Evidence Rating for Strength of Guideline Recommendations
The task force appraised the strength of the evidence for the recommendations in the guideline according to a level-of-evidence taxonomy based on the following categories: level A, B, or C or Task Force Consensus (Table 4). The rating refers to the strength of the evidence for a recommendation and does not relate to the importance of the recommendation. Studies that support the recommendations are summarized in the full text of the guideline.

Assessment of Benefit/Effectiveness Versus Harm of Recommendations
To facilitate clinical decision-making, the recommendations in the guideline were reviewed and classified by the task force based on an assessment of the potential benefits/effectiveness versus a lack of benefit/effectiveness or harms of a procedure or treatment according to the evidence and/or expert opinion presented in the guideline. See Table 5 for the criteria used to classify the recommendations according to potential benefit/effectiveness versus harm.

Final Review and Completion of the Guideline
The completed guideline underwent peer review by an independent group of 4 certified wound, ostomy, and continence nurses (CWOCNs); 1 certified wound and ostomy nurse (CWON); and 1 certified ostomy and continence nurse (COCN) who evaluated it based on relevance, clarity, accuracy, comprehensiveness, organization, consistency with current research/best practices, and usefulness to the target population. Feedback was reviewed by the task force and incorporated into the final document as appropriate.

SUMMARY OF RECOMMENDATIONS—CLINICAL GUIDELINE: MANAGEMENT OF THE ADULT PATIENT WITH A FECAL OR URINARY OSTOMY

A. Stoma Construction
1. Construct fecal and urinary stomas, whenever possible, to protrude above the surface of the skin. Level of Evidence: C (Class I)
2. Mature ileostomies and urostomies at least 2 cm above the level of the skin’s surface to help minimize peristomal leakage. Level of Evidence: C (Class I)
B. Preoperative Education

1. Include education by a specialty nurse, such as a WOC nurse, in preoperative education of patients undergoing ostomy surgery. Level of Evidence: B (Class I)

2. Focus on self-care of the ostomy and/or assistance of a caregiver, as needed, when providing preoperative ostomy education. Level of Evidence: C (Class I)

C. Stoma Site Marking—Ensure preoperative stoma site marking is performed by a trained clinician to promote patient independence in stomal care, promote resumption of normal activities of daily living, and reduce postoperative complications. Level of Evidence: B (Class I)

D. Selection of an Ostomy Pouching System

1. Establish a pouching system that maintains a seal for a predictable amount of time without leakage and protects the peristomal skin. Level of Evidence: C (Class I)

2. Advise the patient to seek assistance from a WOC nurse or a nurse skilled in ostomy care to assist in the selection of an effective pouching system. Level of Evidence: C (Class I)

3. Consider the following factors when selecting a pouching system: type of ostomy, stoma type and location, abdominal contours, lifestyle, personal preferences, visual acuity, and manual dexterity. Level of Evidence: C (Class I)

4. Measure the stoma and fit the opening in the skin barrier of the pouching system to the size and shape of the stoma. Level of Evidence: C (Class I)

5. Consider using convexity when wear time of the pouching system is not desirable, the peristomal skin is creased (wrinkles/folds), the stoma is retracted and/or flush, the opening of the stoma (os) is at/or below the skin level, and/or if the peristomal skin is flaccid. Level of Evidence: C (Class I)

TABLE 3.
Criteria for Level-of-Evidence Ratings for Research Evidence

<table>
<thead>
<tr>
<th>Level of Evidence</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>Level I</td>
<td>An RCT demonstrating a statistically significant difference in at least 1 important outcome defined by ( P &lt; .05 ). Level I trials can conclude the difference is not statistically significant if the sample size is adequate to exclude a 25% difference among study arms with 80% power.</td>
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<tr>
<td>Level II</td>
<td>An RCT that does not meet level I criteria.</td>
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<tr>
<td>Level III</td>
<td>A non-RCT with contemporaneous controls selected by some systematic method. A control might have been selected due to its perceived suitability as a treatment option for an individual patient.</td>
</tr>
<tr>
<td>Level IV</td>
<td>A before-and-after study or a case series of at least 10 patients using historical controls or controls drawn from other studies.</td>
</tr>
<tr>
<td>Level V</td>
<td>A case series of at least 10 patients with no controls.</td>
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<tr>
<td>Level VI</td>
<td>A case report of fewer than 10 patients.</td>
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</tbody>
</table>

Abbreviation: RCT, randomized controlled trial.

*From Wound, Ostomy and Continence Nurses Society.* Used with permission.
6. Consider using accessory ostomy products if needed to enhance the effectiveness of the adhesive seal of the pouching system and/or protect the peristomal skin. Level of Evidence: C (Class I)

7. Determine the type of pouching system (1- or 2-piece) for the person with a stoma based on the physical needs and personal preferences of the individual. Level of Evidence: C (Class I)

E. Postoperative Education—Include the following key components in postoperative education before the patient is discharged from the hospital: assessment and care of the stoma and peristomal skin, pouch emptying, changing the pouching system, drainage collectors for urostomies, managing gas and odor, common complications, clothing, diet and fluid guidelines, medications, use of a medical alert bracelet by a patient with a continent ostomy, and obtaining supplies. Level of Evidence: B (Class I)

F. Postoperative Management Issues

1. Consider colostomy irrigation as one of the management options for the person with a sigmoid or descending colostomy. Level of Evidence: C (Class II)

2. Provide counseling and support to the person with an ostomy based on an assessment and identification of cultural, religious, and sexual/intimacy issues. Level of Evidence: C (Class II)

3. Implement measures to manage a high ileostomy output. 
   a. Educate the person with a high ileostomy output on appropriate interventions, according to his or her individualized treatment plan.
   - Types of fluids to ingest: 
     - Decrease hypertonic and hypotonic fluids.
     - Include high sodium and complex starches in the diet.
     - Avoid sugary drinks, including juices.
   - Measure and record ileostomy and urinary output.
   - Monitor and record weights.
   - Use antidiarrheal medications, such as loperamide, as directed by the healthcare team.
   - Seek medical attention when high output and signs/symptoms of dehydration are present.

b. Consider use of an extended-wear skin barrier, and evaluate the wear time for patients with a high ileostomy output to prevent stomal effluent from eroding and undermining the skin barrier seal and causing peristomal skin damage and leakage of the pouching system.

c. Consider developing and implementing a pathway, protocol, or plan of care that addresses management of a high ileostomy output.

4. Obtain a urine sample for culture from a urostomy by catheterizing the stoma, which is the preferred method. Level of Evidence: C (Class II)

G. Follow-up Care After Discharge From the Acute Care Setting—Utilize a standardized approach to provide ongoing follow-up care and support to patients with a new ostomy (after their discharge) by an ostomy nurse specialist through an outpatient ostomy clinic, a home healthcare agency, and/or telephone follow-up. Level of Evidence: C (Class II)

H. Health-Related Quality of Life for the Person With an Ostomy

1. Include information about the effects of surgery on HRQOL in preoperative education.

2. Provide 12 months of follow-up after surgery to promote effective coping with an ostomy.

3. Refer individuals with new ostomies who have a severe or prolonged decrease in their HRQOL to appropriate healthcare providers.

### TABLE 4.

<table>
<thead>
<tr>
<th>Level of Evidence Rating for Strength of Guideline Recommendations*</th>
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<tbody>
<tr>
<td>Level A</td>
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<td>Level B</td>
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<td>Level C</td>
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Task force consensus: The recommendation represents a consensus of the task force members.

Abbreviation: RCT, randomized controlled trial.
*From Wound, Ostomy and Continence Nurses Society. Used with permission.

### TABLE 5.

<table>
<thead>
<tr>
<th>Classification of Recommendations: Potential Benefit/Effectiveness Versus Harm*</th>
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<tr>
<td>Class I</td>
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<td>Class II</td>
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<td>Class III</td>
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<td>Class IV</td>
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Is indicated and recommended; should be done.
May be indicated; is reasonable to perform; may be considered.
May be reasonable; may be considered in select instances.
Is not indicated or recommended; should not be performed.

*From Wound, Ostomy and Continence Nurses Society. Used with permission.
4. Provide information to individuals with new ostomies about community-based ostomy groups, ostomy visitors, and online ostomy support groups.
Level of Evidence: C (Class I)

I. Stomal and Peristomal Complications

1. Mucocutaneous separation.
   a. Treat the mucocutaneous separation according to the depth and degree of the defect:
      • Consider sprinkling stoma powder over the separation to absorb moisture and promote better pouch adherence if the separation is shallow.
      • Consider filling the separation with an absorbent product, such as an alginate or gelling fiber, and covering it with a solid hydrocolloid or the pouch's skin barrier if the separation has depth.
   b. If risk of infection is a concern, consider using an antimicrobial dressing in addition to systemic treatment.
   c. Determine appropriate systemic antibiotic therapy if infection occurs.
Level of Evidence: C (Class II)

2. Stomal necrosis.
   a. Consider marking the potential stoma site in an obese patient in the upper abdominal quadrant, which may decrease the extent of surgical dissection of the mesentery that is necessary and minimize vascular compromise to the stoma.
Level of Evidence: C (Class II)

b. Manage stomal necrosis according to the level of ischemia and necrosis:
   • Monitor and observe the stoma if the necrosis is superficial. The top layer of tissue may slough off over time, revealing a red viable stoma.
   • Determine if debridement of the nonviable stomal tissue is necessary if the ischemia and necrosis are deeper.
   • Refer the patient for emergent surgical revision if necrosis is below the fascial level.
Level of Evidence: C (Class II)

3. Stomal retraction.
   a. Attempt to augment the height of the stoma above the level of the skin when the stoma is flush or retracted:
      • Consider the use of a convex pouching system and/or a belt.
      • Consider the risks and benefits of convexity. There is little evidence in the literature regarding how soon after ostomy surgery convexity may be introduced.
   b. Determine if surgical intervention is necessary to revise the stoma if a predictable wear time is not achieved and complications are persistent.
Level of Evidence: C (Class II)

4. Stomal stenosis.
   a. Advise patients with mild stenosis of a fecal ostomy to change their diet and reduce insoluble fiber, use stool softeners, and increase their fluid intake to keep the stool soft.
   b. Consider stomal dilation only on a temporary basis to aid in evacuation. Due to a lack of evidence, dilation is not recommended as a long-term practice, and chronic use of dilation is associated with stomal stenosis.
   c. Determine if surgery is necessary to correct the stenosis.
Level of Evidence: C (Class II)

5. Stomal prolapse.
   a. Consider the following interventions:
      • Adjust the size of the pouch and the opening in the skin barrier to prevent trauma to the stoma.
      • Use a hernia support belt with a prolapse attachment.
      • Determine if a 1-piece pouching system might minimize trauma to the prolapsed stoma, depending on the length of the prolapse.
      • Educate the patient or caregiver regarding techniques to reduce the prolapsed stoma, assessment of the prolapsed stoma for color changes, and to seek medical attention if the stoma becomes dusky or ischemic.
   b. Refer the patient for an urgent surgical evaluation if the blood supply is compromised and the prolapsed stoma cannot be manually reduced.
Level of Evidence: C (Class I)

6. Peristomal (also known as parastomal) hernia.
   a. Seek a surgical opinion when a hernia is present. It may be better to have the hernia repaired at an early stage, rather than waiting until the patient is older and has a higher risk for surgical complications.
   b. Consider the following interventions: Use a hernia support belt, discontinue colostomy irrigations if water and stool do not easily return, and use a flexible pouching system to prevent peristomal skin trauma.
   c. Instruct patients to immediately report the following symptoms to their healthcare provider: stoma darkens in color or unremitting pain; no gas, stool, or urine from the stoma; or bloating, nausea, vomiting, and loss of appetite.
   d. Refer the patient for urgent surgical intervention if the hernia incarcerates and/or the color of the stoma changes.
Level of Evidence: C (Class I)

7. Stomal trauma.
   a. Properly size the pouching system to prevent trauma, and assess the stoma for injury during routine pouch changes.
   b. Advise the patient to use caution and consider using stoma protection devices when participating in sports/activities.
   c. Instruct the patient to promptly report persistent bleeding or bleeding that comes from inside the stoma to the healthcare provider to rule out other disease-related complications.
Level of Evidence: C (Class I)

8. Stomal fistula.
   a. Ensure the pouching system is fitted properly and adequately protects the peristomal skin.
   b. Correct any underlying medical condition(s) that might contribute to the development of a fistula (eg, Crohn's disease).
   c. Consider surgical intervention to revise or relocate the stoma if the stomal fistula cannot be managed by making alterations in the pouching system.
Level of Evidence: C (Class I)

9. General peristomal recommendations.
   a. Identify and manage the underlying cause of peristomal complications while providing appropriate care.
Level of Evidence: C (Class I)
b. Evaluate the peristomal skin. Remove the ostomy pouching system and assess the peristomal skin. Examine the back of the skin barrier (the adhesive side) to see if stomal effluent has been getting under the skin barrier, and determine if leakage is affecting the condition of the skin. Level of Evidence: C (Class I)

c. Ensure the pouching system fits well throughout treatment to protect the peristomal skin and prevent additional damage (ie, covers the skin around the stoma; maintains a seal for a predictable amount of time without leakage). Change the type of pouching system and the frequency for changing the pouching system, if needed, while the skin is healing.

Level of Evidence: C (Class I)

10. Peristomal moisture-associated skin damage.

a. Determine the cause of the skin damage, and modify the ostomy pouching system or how it is used to prevent further damage.

b. Provide a pouching system that fits closely around the stoma and prevents leakage under the skin barrier.

c. Advise the patient with a urostomy to connect the pouch to a bedside drainage bag at night to help prevent urine from undermining the skin barrier and causing leakage.

d. Treat damaged skin with stoma powder and a no-sting barrier film or a solid skin barrier, as indicated.

e. Consider local treatment of wart-like lesions:
   • Cauterize lesions with silver nitrate.
   • Apply vinegar and water soaks to the affected area while the pouching system is off.
   • Evaluate any lesions that do not resolve to rule out possible malignancy.

Level of Evidence: C (Class I)

11. Peristomal fungal/candidiasis infection.

a. Apply topical, antifungal powder (no creams) to the affected area before attaching the ostomy skin barrier and/or use oral or intravenous antifungal medications for persistent or severe infections, if necessary.

b. Eliminate moisture from the affected area: Instruct the patient to change the pouch if moisture has gotten beneath the skin barrier.

Level of Evidence: C (Class I)

12. Peristomal allergic contact dermatitis.

a. Identify and discontinue use of the allergen: Patch testing may be helpful.

b. Apply a topical corticosteroid spray to manage inflammation and provide symptom relief. Avoid creams and ointments, which interfere with adherence of the pouching system.

c. Adjust the frequency of pouch changes, if needed. The patient may need to remove and replace the pouch more often until the skin irritation has resolved.

Level of Evidence: C (Class I)

13. Peristomal mechanical skin damage: Medical adhesive-related skin injury (MARSID).

a. Determine the cause of the injury, and modify the pouching system or how it is used to prevent further injury.

b. Manage open skin area(s) by applying stoma powder or an absorbent dressing prior to application of the solid skin barrier.

c. Consider selecting a pouching system without tape borders if tape is contributing to the skin injury, and use adhesive removers when changing the solid skin barrier.

d. Consider use of skin barrier films to help protect intact, fragile skin.

Level of Evidence: C (Class I)


a. Identify and remove the source of the pressure, treat the wound, and provide an alternate pouching system.

b. Use absorbent products such as stoma powder, alginate dressings, and polyurethane foam to absorb excess moisture from healing wounds.

c. Instruct the patient to change the pouch more frequently until the wound has healed to ensure moisture does not accumulate beneath the skin barrier.

Level of Evidence: C (Class I)

15. Peristomal varices.

a. Apply direct, local pressure in the case of acute bleeding; cautery and hemostatic or gel foam may be needed in severe cases.

b. Refer patients with uncontrolled hemorrhage for urgent medical attention.

c. Use skin barriers that are easily removed, and use adhesive removers when possible.

d. Avoid using rigid ostomy products that may cause injury.

e. Refer the patient for a medical workup to determine the etiology of varices and possible treatment.

Level of Evidence: C (Class I)


a. Use an antibacterial skin cleanser on the affected area.

b. Apply topical antibiotic powder in severe cases.

c. Reduce the frequency of shaving or use clippers.

d. Educate the patient about the condition and how to manage it.

e. Consider methods of permanent hair removal for patients with permanent stomas and problematic or persistent folliculitis.

Level of Evidence: C (Class II)

17. Peristomal pyoderma gangrenosum.

a. Manage ulcer pain.

b. Evaluate the patient for a secondary infection, and treat the underlying disorder by reducing the inflammatory process.

c. Provide appropriate topical care:
   • Absorb excess moisture to facilitate pouch adhesion.
   • Fill the wound with an absorbent product, such as an alginate or gelling fiber, to facilitate adherence of the ostomy skin barrier.
   • Adjust the frequency of pouch changes to ensure moisture does not accumulate on the intact skin.
   • Consider topical treatment of mild PG with tacrolimus, which, based on reports from treatments of small numbers of patients, may be effective to promote healing.
SUMMARY

Individuals undergoing ostomy surgery and living with an ostomy, whether temporary or permanent, face multiple challenges and lifestyle changes that require education and care from healthcare professionals with specialized knowledge and skills. The purpose of the guideline and this executive summary is to facilitate the care and management of patients with an ostomy or undergoing ostomy surgery by providing recommendations for care based on the current available research and/or expert opinion in areas where evidence is lacking. This executive summary provides an overview of the process for updating and developing the WOCN Society’s Clinical Guideline: Management of the Adult Patient With a Fecal or Urinary Ostomy5 and includes the specific recommendations from the guideline. Refer to the Supplemental Digital Content 1 (available at: http://links.lww.com/JWOCN/A40) associated with this article for a complete reference list for the guideline. The full text of the published guideline, which includes the evidence supporting the recommendations and a complete reference list, is available in print or as a mobile application from the WOCN Society’s online bookstore (http://www.wocn.org).

KEY POINTS

- An individual undergoing ostomy surgery, whether temporary or permanent, faces many challenges and lifestyle changes.
- Ostomy surgery continues to have high rates of surgical complications, with an unadjusted morbidity rate of 42.9% and a mortality rate of 10.7%.
- Best practices for ostomy care include preoperative stoma site marking, early identification of stomal and peristomal problems, and timely intervention directed at the cause of the problem.
- Ostomy specialists such as WOC nurses are essential for preoperative and postoperative education of patients undergoing ostomy surgery, including long-term access to the specialist for problems.
- To facilitate adaptation of the person living with a stoma, coordination of care is required across healthcare settings and among all disciplines that provide care to the person with an ostomy.

ACKNOWLEDGMENTS

Hollister Incorporated (Libertyville, Illinois) provided an educational grant for the production of the guideline. One task force member is an employee of Hollister Incorporated; however, Hollister had no input into the clinical content of the guideline. The task force acknowledges Ronald Palmer (scribe) and librarians Kara McGuire and Andrea Sullivan for their contributions to the development of the 2017 Clinical Guideline: Management of the Adult Patient With a Fecal or Urinary Ostomy.

REFERENCES


