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A stomanurse's nightmare - unforeseen complications after parastomal hernia repair

Introduction & Objectives

The difficult case that we've encountered concerns a patient with an unforeseen complication after a parastomal hernia repair surgery. The urostomy which the patient had for 9 years at the time of admission, has fallen into the abdomen following the dehiscence of the surgical wound. It was holding on the fascia and ejecting urine into the intraabdominal cavity. When the patient was admitted to our ward, she came in with gauze dressings around and inside the wound, which were not doing much for the urine absorption. You could see the hernia mesh inside the wound with some plaque on it, the edges of the wound were necrotic and there was a drain in the distal side of the laparotomy. The patient was extremely uncomfortable, scared to even stand up from the bed because of the leaking from her wound. She was not eating due to her stress and feeling of hopelessness, which was slowing down any healing process.

Materials & Methods

We started off by cleaning it, inserting hydrogel and Actisorb Plus inside the cavity to reduce the plaque and bacteria inside and absorb the secretion. We used hydrocolloid strips on the edges, barrier film to protect the skin and a postoperative stomabag with a window, so we could keep an eye on the wound, accomodate the catheter and change the fillings if need be. We also used a pediatric stomabag on the drain to increase the patients comfort, with no hanging tubes she was able to walk around. We also called a nutrition specialist to help us increase the patient's protein intake, as she had no real appetite. Her mood increased tenfold after these interventions, she started to feel hopeful that she might be able to go home soon. After several weeks of treatment with the hydrogel and Actisorb combination, the wound was clean, with no plaque. After several weeks of treatment with Actisorb, the wound was completely clean and granulating, we were able to switch to Promogran collagen matrices to increase the granulation inside the cavity.

Results

After one month, the patient was dismissed home. She came in for the first checkup 2 days later, where we changed the catheter to a Foley with a central opening, so that we could use a wire to change it, as the wound started to heal more and more we were losing sight of the ostomy inside. After the switch to Promogran matrices, the wound started to close up quickly, we were able to reduce the need for checkups to twice a week, then later just once. The wound closed up completely and has formed a canal around the catheter, which serves as a urine derivation. We have managed to educate the patient's daughter so that she's able to change her ostomy bags and flush the catheter with saline solution in case of a blockage. As the patient is unable to change the ostomy bag herself physically, we have also cooperated with a home care ostomy nurse who is taking care of the bag changes most work days. The patient is now fully able to function normally with minimal incidents of leakage or blockage and necessary trips to the hospital.

Conclusions