

OSTOMY CARE



## *ASCRS and WOCN Joint Position Statement on the Value of Preoperative Stoma Marking for Patients Undergoing Fecal Ostomy Surgery*

The American Society of Colon & Rectal Surgeons (ASCRS) collaborated with the Wound, Ostomy and Continence Nurses (WOCN) Society in 2007 to develop a position paper to establish that every person scheduled for a fecal diversion should be marked for a stoma preoperatively by a skilled health care provider. The WOCN Ostomy subcommittee chaired by Jane Carmel led this important activity. The genesis of the project was the development of a stoma marking video developed by the ASCRS for their fellowship program. Several WOC nurses collaborated on this video and the group agreed that this collaboration should continue to address the issue of stoma site marking. The WOCN Ostomy subcommittee chair worked with 8 WOCN members from around the country. Subcommittee members performed a literature search to support the need for stoma site marking. Most references were found to be international citations with a few limited current studies. Once the literature search was completed, the WOCN subcommittee divided into two groups, one to develop the position statement, the other charged with developing the procedure for stoma site marking. The two documents were developed using the existing literature as well as the expert opinion of the subcommittee. Dr. Ann Lowry of the ASCRS spearheaded the work of the ASCRS and sent the document to a group of identified ASCRS experts. After editing was completed, the Boards of the ASCRS and the WOCN approved the documents.

This collaborative project produced a document that supports the need for preoperative stoma site marking and provides a template for the selection of the proposed stoma site that can be used by WOC nurses and surgeons alike. While the outcome in reduction of stoma complications and improvement in the quality of life for persons with an ostomy will need validation, this important first step will guide future research.

The American Society of Colon & Rectal Surgeons (ASCRS) and the Wound Ostomy Continence Nurses Society (WOCN) recommend that all patients scheduled for ostomy surgery should have stoma marking done preoperatively by an experienced, educated and competent clinician.

A preoperative visit is preferred for the patient scheduled to have ostomy surgery for both assessment and education of the patient and their family about their future ostomy. Stoma site selection should be a priority during the preoperative visit. Marking the site for a stoma preoperatively allows the abdomen to be assessed in a lying, sitting and standing position. Evaluation in these multiple positions allows determination of the optimal site. This evaluation can help reduce postoperative problems such as leakage, fitting challenges, need for expensive custom pouches, skin irritation, pain and clothing concerns. Poor stoma placement can cause undue hardship and have a negative impact on psychological and emotional health. Proper placement of the stoma enhances patient independence in stoma care and resumption of normal activity. Furthermore, this preoperative visit allows the patient and their family to begin learning about stoma care and the use of ostomy appliances prior to surgery at a time when they are less distracted than in the immediate post-operative period.

Colon and rectal surgeons and ostomy nurses are the optimal providers to mark stoma sites, as this is a part of their education, practice and training. In cases where a colon and rectal surgeon or ostomy nurse is unavailable to perform stoma site marking, a trained clinician can perform the procedure.

Preoperative site markings are a guide, and are not necessarily the final surgical site. The final site selection is done by the surgeon once the abdominal cavity is entered and the condition of the bowel is determined.

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■ **ASCRS Committee Members.** Amir Bastawrous, MD; Gary Dunn, MD; C. Neal Ellis, MD; Neil Hyman, MD; Walter Koltun, MD; Ann Lowry, MD; Les Rosen, MD; Janice Rafferty, MD; Alan Thorson, MD; Eric Weiss, MD.

ASCRS and WOCN have developed an educational guide to assist clinicians in performing this procedure.

*Adopted by ASCRS Board 4.17.07*

## ■ Stoma Siting Procedure

### Subject:

Stoma Siting Procedure

### Purpose:

Marking the site for a stoma preoperatively allows the abdomen to be assessed in a lying, sitting and standing position. Such an assessment allows the determination of the optimal site. This planning can help reduce post-operative problems such as leakage, fitting challenges, need for expensive custom pouches, skin irritation, pain and clothing concerns. Poor placement can cause undue hardship and impact psychological and emotional health. Good placement enhances the likelihood of patient independence in stoma care and resumption of normal activities.

Colon and rectal surgeons and ostomy nurses are the optimal providers to mark stoma sites, as this is a part of their education, practice and training. In cases where a colon and rectal surgeon or ostomy nurse is unavailable, the following procedure provides key points to consider when siting a stoma.

### Key Points to Consider

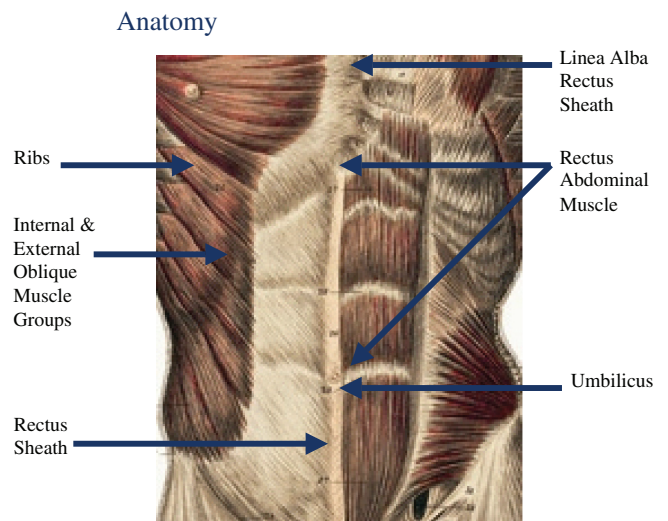
- Positioning issues: contractures, posture, mobility (e.g., wheelchair confinement, use of walker, etc.)
- Physical considerations: large/protruding/pendulous abdomen, abdominal folds, wrinkles, scars/suture lines, other stomas, rectus muscle, waist line, iliac crest, braces, pendulous breasts, vision, dexterity, presence of hernia.
- Patient considerations: diagnosis, history of radiation, age, occupation
- Other: surgeon preferences, patient preferences, type of ostomy or diversion, anticipated stool consistency.
- Multiple stoma sites: mark fecal and urinary stomas on different horizontal planes/lines.

### Procedure:

1. Gather items needed for the procedure:
  - Marking pen, surgical marker, transparent film dressing, flat skin barrier (according to surgeon's preference and facility policy).
2. Explain stoma marking procedure to patient, and encourage patient participation and input.
3. Carefully examine patient's abdominal surface. Begin with patient fully clothed in sitting position with feet on floor. Observe the presence of belts, braces and any other ostomy appliances.

4. Examine patient's exposed abdomen in various positions (standing, lying, sitting and bending forward) to observe for creases, valleys, scars, folds, skin turgor and contour.
5. Draw an imaginary line where the surgical incision is going to be. Choose a point approximately 2 inches from the surgical incision where 2-3 inches of flat adhesive barrier can be placed.
6. With patient lying on back identify the rectus muscle. [This can be done having the patient do a modified sit-up (raise the head up off the bed)]. Placement within the rectus muscle can help to prevent peristomal hernia formation and/or prolapse.

**See picture below to identify desirable surface areas to mark:**



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7. Choose an area that is visible to the patient, and if possible below the belt line to conceal the pouch.
8. If the abdomen is large, choose the apex of the mound or if the patient is extremely obese, place in the upper abdominal quadrants.
9. It may be desirable to mark sites on the right and left sides of the abdomen to prepare for a change in the surgical outcome (you may want to number your first choice as #1).
10. Clean the desired site with alcohol and allow to dry. Then proceed with marking the selected site with a surgical marker/pen. You may cover with transparent film dressing if desired to preserve the mark.
11. Once marked have the patient assume sitting, bending and lying positions to assess and confirm best choice. It is important to have the patient confirm they can see the site.