Use of a

CeraPlus™ Skin Barrier

with Remois Technology*

Hollister Education™

Case Study 15

Abstract

There is a high incidence of peristomal skin complications, with more than half of all people living with an ostomy experiencing a peristomal skin issue at some point in their lifetime[1]. The types of complications, the reasons for them, and the solutions used to treat them can vary widely. For clinicians, managing these peristomal skin complications takes time and effort. For patients, sore peristomal skin can have a negative impact on their quality of life. Peristomal skin complications are the most common post-operative complication following creation of a stoma[2]. One such story will be shared in this case study.

Aim

To visibly improve and maintain peristomal skin integrity by finding a suitable skin barrier formulation for the patient, and ensuring a proper skin barrier fit around the stoma.

Patient Overview

This female patient is a young adult who was diagnosed with Ulcerative Colitis three years ago. Her family history includes Crohn's Disease. Patient failed medical management and opted for a subtotal proctocolectomy and ileoanal anastomosis (J Pouch). The surgery resulted in a temporary end ileostomy.

Initially a two-piece extended wear moldable flat skin barrier and transparent drainable pouch was applied. This pouching system started leaking four hours after application and the patient became anxious when the tape collar detached from the skin. The WOC nurse switched her from a moldable barrier to a two-piece extended wear flat cut-to-fit skin barrier. The patient was discharged home in this pouching system and would be followed by the home health nurses.

Problem and Interventions

On post-op day 10, the patient became very concerned about a "small gap" that had developed between the stoma and the skin. The patient was assessed in clinic and a mucocutaneous separation was noted at adjacent to the stoma at three o'clock. The WOC nurse instructed the patient in topical wound management consisting of an alginate dressing secured by steristrips. Another wound was also noted from eleven to twelve o'clock and had been documented by the surgeon as a small surgical burn. This wound was partial thickness and did not require a dressing (Photo 1). During this visit the patient was also introduced and switched to a two-piece **CeraPlus** cut-to-fit flat skin barrier.

On postop day 26, the patient texted a follow-up photo to the WOC nurse noting that the "small gap" at the stoma edge and the wound above the stoma was improving (Photo 2).

Two months post-op, the patient sent a text to the WOCN complaining her skin was "so painful and burning". A photo accompanied the text message in which the patient had circled her areas of concern (Photo 3). The patient was seen as an outpatient so the WOC nurse could assess this new wound. Her pain seemed disproportionate to the size of her wounds and Pyoderma Gangrenosum (PG) was suspected. A hydrofiber dressing was provided and an over the counter cortisone ointment was also recommended to be applied

continued on back

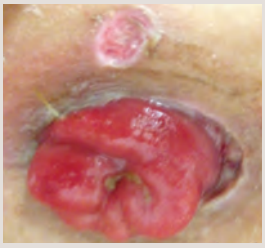

Photo 1 A mucocutaneous adjacent to the stoma and partial thickness wound noted to the peristomal skin.

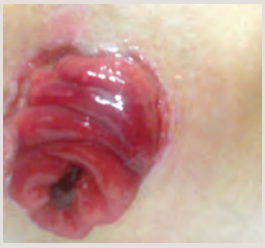

Photo 2 Peristomal skin after sixteen days. Improvement noted to mucocutaneous separation and wound.

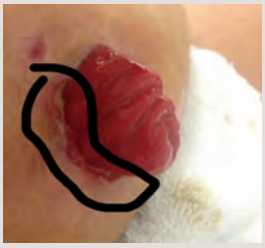

Photo 3 At two months patient complained of pain and burning.

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Contributing Author and Affiliations
Amparo Cano RN, MSN, CWOCN
University of Miami Hospital
Miami, Florida

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to painful areas. A two-piece CeraPlus flat pre-sized skin barrier was chosen to ensure a consistent fit, cover the wound and help avoid further trauma to the peristomal skin.

Twelve days later, the patient texted a photo of a full thickness ulceration adjacent the stoma (Photo 4). This photo was shared with her surgeon who prescribed a topical immunosuppressant ointment. The hydrofiber dressing was continued to the ulceration and the WOC nurse recommended she use a remover spray every time she removed her skin barrier. The patient "loved" the CeraPlus skin barrier and wanted to continue with it.

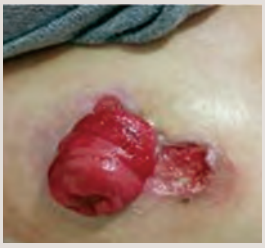

Photo 4 Full thickness ulceration developed adjacent the stoma over two months post op.

Outcomes

Four days later, the patient texted a photo stating, "This is amazing! I changed my bag yesterday and look how much better it is. This is in only four days of having the cream on" (Photo 5). The patient felt the ulceration was starting to improve and the area was no longer as painful.

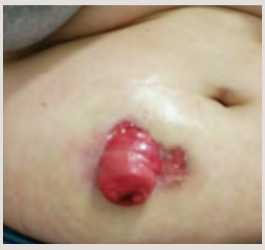

Photo 5 Improvement noted to ulceration after four days of using topical immunosuppressant.

Conclusion

Many people with ostomies experience peristomal skin issues and accept them as a normal aspect of having a stoma[3]. Thankfully, this patient sought help and there was visible improvement of the peristomal skin. Achieving a good fit around the stoma, preventing leakage and managing specific health issues as a means of mitigating skin irritation may not be enough to keep the peristomal skin healthy. The formulation of a skin barrier also has an impact on the health of the peristomal skin. Finding the right combination of skin barrier formulation,
and skin barrier fit is essential to maintaining a healthy peristomal skin environment.

References:

1. Richbourg L, Thorpe J, Rapp C. *Difficulties experienced by the ostomate after hospital discharge.* J Wound Ostomy Continence Nurs. 34(1):70. 2007.
2. Meisner S, Lehur P-A, Moran B, Martins L, Jemec GBE. *Peristomal Skin Complications Are Common, Expensive, and Difficult to Manage: A Population Based Cost Modeling Study.* PLoS ONE. 2012; 7(5): e37813.
3. Whiteley IA and Sinclair G *A Review of Peristomal Skin Complications Following the Formation of an Ileostomy, Colectomy or Ileal Conduit.* World council of Enterostomal Therapists Journal, 2010; 30(3) p. 23-29.

The support of Hollister Incorporated is gratefully acknowledged.

This case study represents one nurse's experience in using a CeraPlus skin barrier with a specific patient and may not necessarily be replicated.

Remois

*Remois is a technology of Alcare Co., Ltd.

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Hollister Incorporated
2000 Hollister Drive
Libertyville, Illinois 60048 USA
1.800.323.4060

www.hollister.com