

# Stoma Relocation

Joshua Katz, M.D.  
Assistant Professor of Surgery  
George Washington University  
Washington D.C.

## Reasons For Relocation

Moving a colostomy, ileostomy or urostomy may seem a strange or bizarre procedure, but it can be quite necessary and improve a patient's quality of life when appropriately and properly performed. Understanding the indications for this surgical procedure requires an understanding of how a stoma is optimally created and managed. When a stoma functions so poorly that it compromises the quality of a patient's everyday life, it needs to be fixed. Sometimes fixing a stoma requires moving the stoma to another site on the abdomen.

The need for a stoma relocation can be determined under a variety of circumstances. Ideally, this should be an elective (meaning scheduled in advance) procedure performed with the understanding of the patient. Counseling by a qualified WOCN (wound ostomy and continence nurse) and preoperative marking of the patient's body for placement of stoma sites are essential to success.

Ideally, the stoma should be located below and to one side of the belly button, away from bone, skin creases and scars. (Figure 1) There should be a smooth, flat area of skin surrounding the stoma upon which to fix the appliance. Properly functioning stomas should be fairly easy to pouch. A patient should be able to see the stoma and care for it easily. If this is not the case, the cost and time to care for a poorly functioning stoma may justify a surgical procedure to correct the problem. Proper stomas should be pouchable with one appliance without change for 3-5 days and should not leak under routine activities and conditions.

## Improper Construction

First, the patient may not have been marked or counseled prior to the surgery. This can occur because some surgeons do not feel it is important to counsel or mark their patients prior to the creation of a stoma. The stoma may have been created during an emergency procedure when there was insufficient time to mark or counsel the patient or the surgeon may not have anticipated the need for a stoma before starting the operation. All these situations can lead to improper placement.

Second, the patient's disease process can stretch the abdomen so that it is impossible to properly mark the site. Finally, sometimes stomas simply cannot be created properly. Critically ill patients sometimes may undergo multiple operations over a relatively short period of time. It may be anatomically impossible to place and construct the stoma properly. Problems with the patient's abdominal wall or the bowel itself can leave the

patient with a poorly located stoma which may not be properly pouched, be prone to leaks and require a complex pouching regimen that is time consuming, unreliable and costly.

## Changes Over Time

A stoma is a dynamic biological structure. Patients who receive a stoma as part of treatment for cancer or inflammatory disease may recover from the effects of that disease and begin to eat better and gain weight. A stoma properly constructed may no longer be so. A person may undergo another procedure or suffer another illness that alters anatomy and function. Skin infections and conditions such as pyoderma gangrenosum can impair stoma care. Recurrent disease, particularly Crohn's, is another cause of ileostomy related complications such as stricture, abscess and fistula. All these conditions may require additional surgery, such as revision of the stoma or possibly relocation.

## Obstruction and Hernia

Two very common problems are postoperative adhesions and peristomal hernia.

Adhesions are the fibrous attachments that result from surgery. They can be minimal or severe. Exactly why they develop and what determines the severity of adhesions is not well understood. Patients with adhesions may develop symptoms of obstruction such as pain, nausea, vomiting and inability to pass stool or gas. Sometimes a bowel obstruction will respond to bowel rest and intravenous fluids. Sometime surgery is required. Operations for obstruction may involve cutting the adhesions and, at times, even bowel resection or revision of the stoma. Additional information on obstruction and adhesions was provided in "Intestinal Obstructions" in the Fall 2002 *Ostomy Quarterly* by Dr. David Beck.

All stomas are technically hernias. A hernia is defined as a defect in the wall of a body cavity. Abdominal hernias can occur after surgery, usually at the incision site. Hernias also occur next to stomas (peristomal hernia) when the opening in the abdominal wall created for the stoma enlarges due to stress, exertion or weight gain. Intestine and other tissues can then bulge through the opening in the muscle layer and push up under the skin (Figure 2). Frequently, peristomal hernias are asymptomatic and the patient may not even know one is present. However, large peristomal hernias may interfere with the fit of an appliance. They can also cause obstruction and pain and may need to be repaired surgically. Peristomal hernias are more common with colostomies than ileostomies.

Options to correct a peristomal hernia include direct repair or stoma relocation. A direct repair is accomplished by removing the hernia sac and closing the hole next to the stoma. This may be accomplished using either simple sutures to close the