Stronger Together

London North West Healthcare NHS
NHS Trust

NURSE-LED AFTERCARE AND MANAGEMENT OF COMPLICATIONS

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IA
The ileostomy & internal pouch Support Group

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Aims and objectives

- Overview of St Mark's Hospital pouch service
- Types of complications
- Management of more common complications
- After care- role of the pouch nursing team

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Facts and figures

- St Mark's Hospital is the primary UK centre
- 6 colorectal surgeons
  - 2 open surgeons
  - 4 laparoscopic surgeons
- 3 pouch nurses, 3 stoma care nurses and 2 HCA's
- 48 new pouches & 2 redo- pouches per annum (2010-14)
- Defunction/excise 12 pouches per annum (2010-14)

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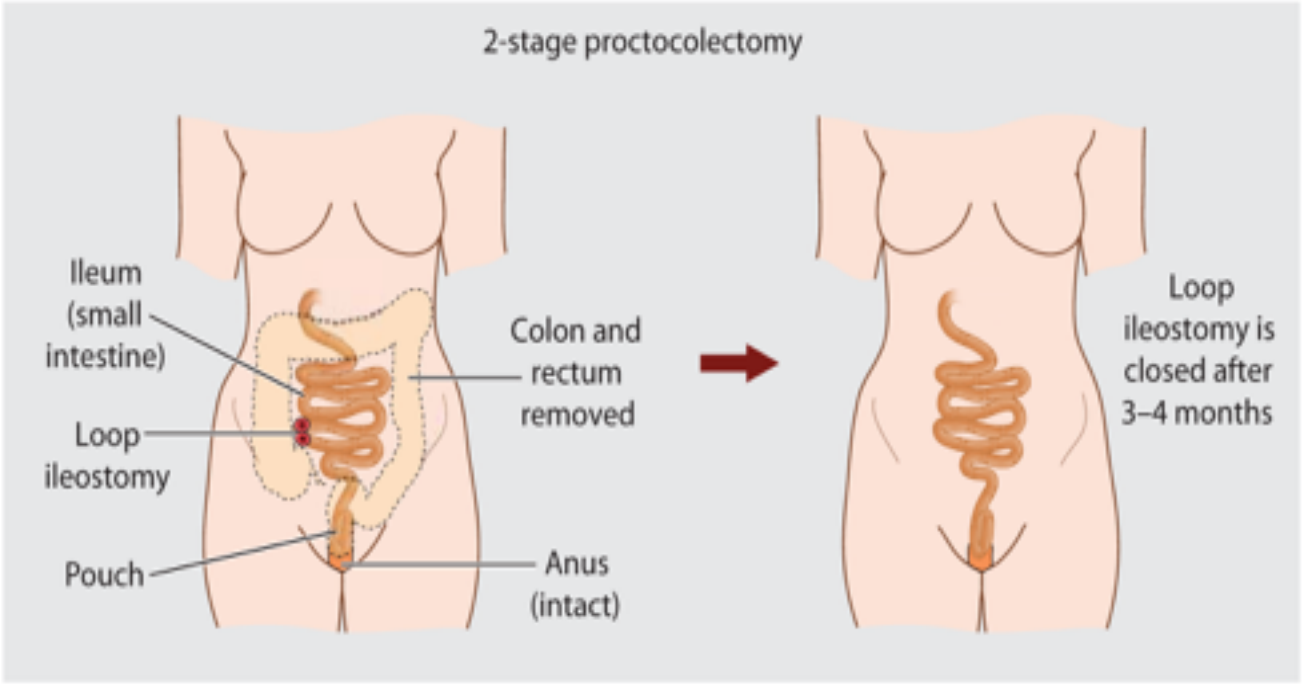
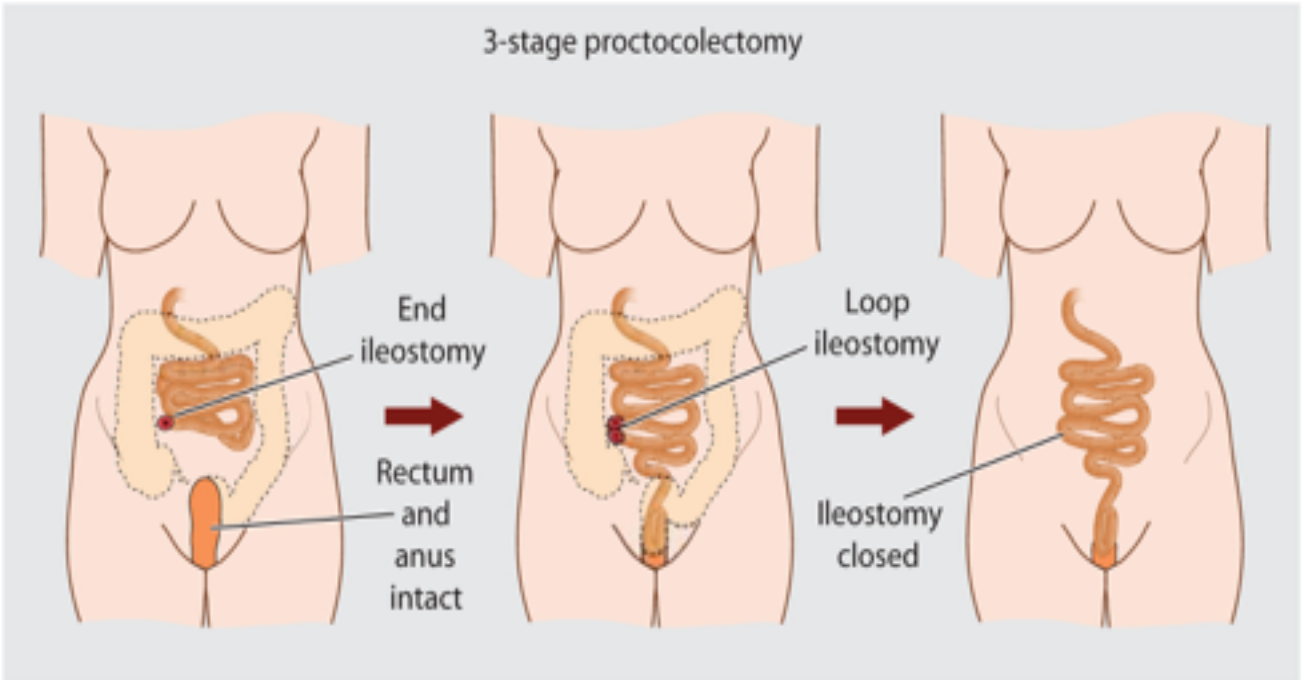
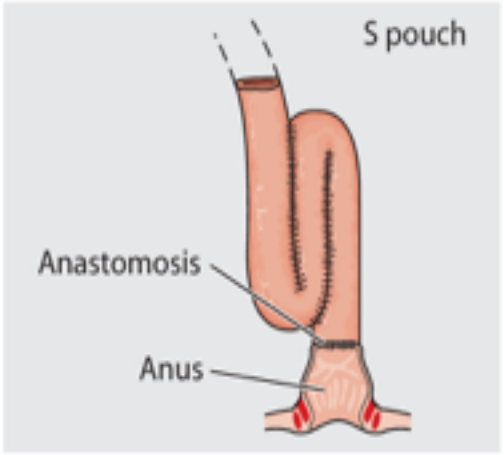
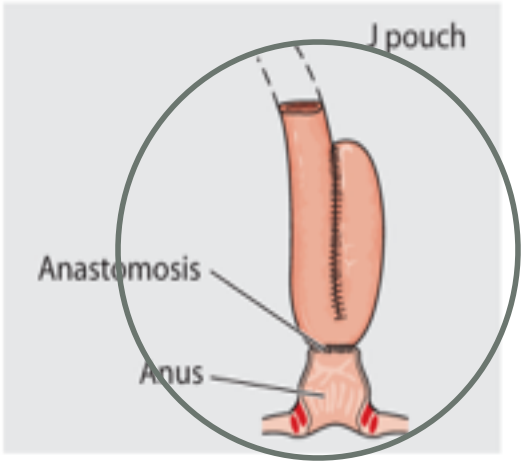
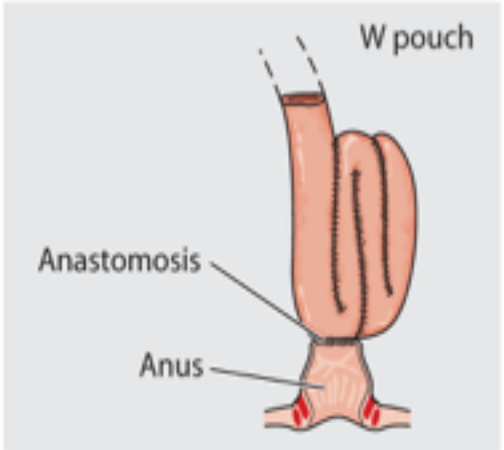

2-stage proctocolectomy
Ileum (small intestine)
Loop ileostomy
Pouch
Colon and rectum removed
Anus (intact)
Loop ileostomy is closed after 3–4 months


3-stage proctocolectomy
End ileostomy
Rectum and anus intact
Loop ileostomy
Ileostomy closed


S pouch
Anastomosis
Anus


J pouch
Anastomosis
Anus


W pouch
Anastomosis
Anus

Normal pouch function

- Normal pouch function : 6-8 times in 24hrs, occasionally one nocturnal motion
- Loose stool (porridge consistency)
- Ability to defer defaecation
- No faecal leakage in the day, may occur at night

Pouch failure

- 10% of pouches fail over a 10 year period and will result in a permanent stoma
- 1/3 of patients are pleased with their pouch and function
- 1/3 can manage their pouch and may need medical/ surgical intervention but deem their pouch overall better than a permanent stoma
- 1/3 of patients have problematic pouches

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Types of complications

1. Early

2. Late

3. Inflammatory

4. Non-Inflammatory

- Mechanical

- Functional

Early/late complications

EARLY

- Wound infection
- Anastomotic leak
- Pelvic collection
- Ileus
- Sepsis
- Obstruction
- Small volume pouch
- Seepage
- Leakage

LATE

- Sepsis
- Inflammatory complications
- Incomplete evacuation
- Stricture
- Fistula
- Pouch failure

Inflammatory pouch dysfunction

- Pouchitis
- Cuffitis
- Pre-pouch ileitis
- Crohn's disease
- Fistulae
- Infective: Clostridium Difficile

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Non-inflammatory pouch dysfunction

- Strictures/small bowel adhesions
- Ineffective emptying of pouch

- Anal sphincter dysfunction
- Pouch-anastomotic leak
- Intra-abdominal collection
- Small volume pouch
- Coeliac disease
- Irritable pouch syndrome
- Bile salt malabsorption

Signs and symptoms of complications

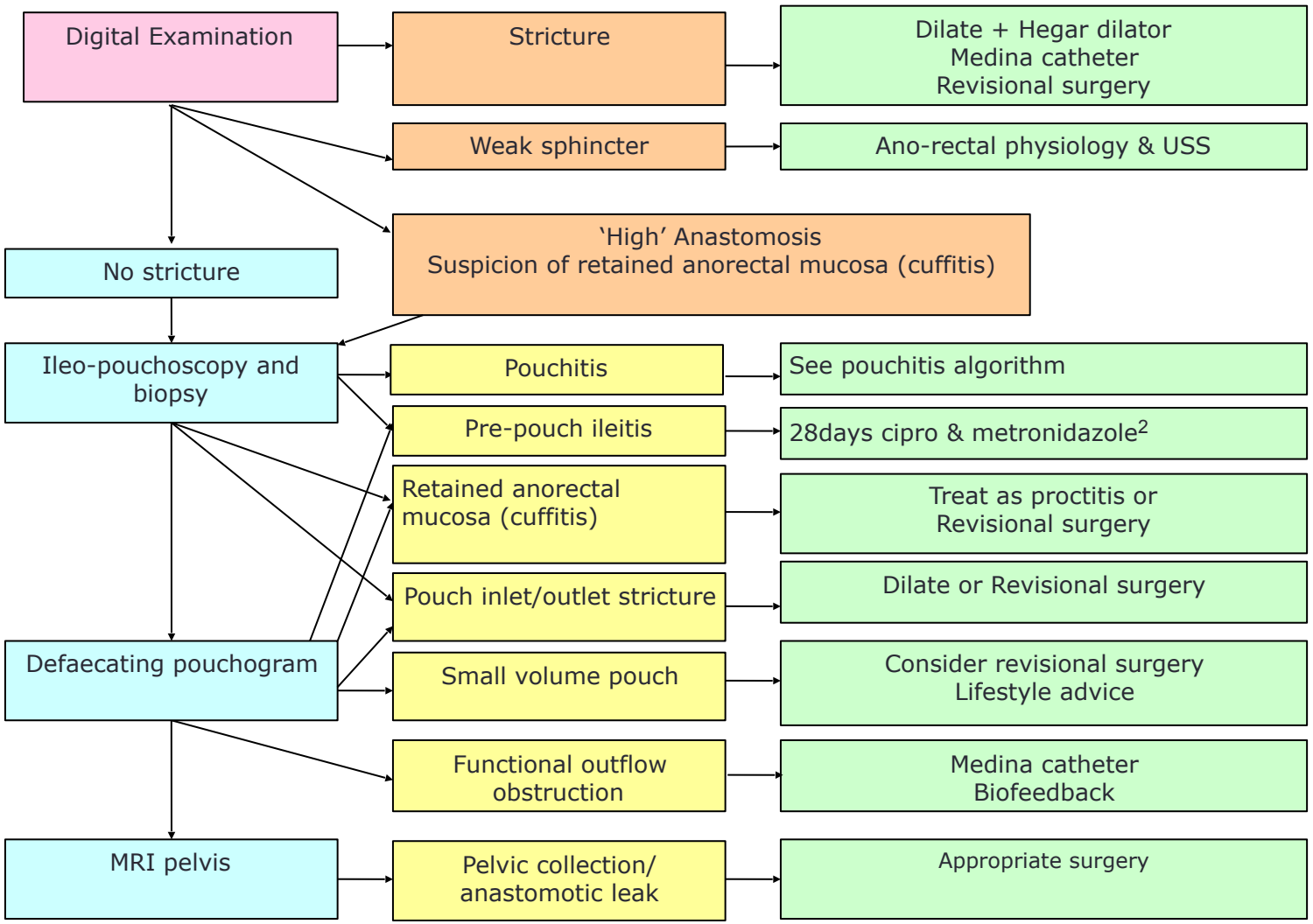
- Pouch frequency and/or urgency
- Bleeding
- Abdominal/back pain
- Fever
- Lethargy
- Ineffective emptying of pouch
- Incontinence
- Symptoms of fistulae (wound breakdown, vaginal/peri-anal discharge, sepsis)

Initial investigations

- Abdominal examination
- Digital exam- strictures, length of anal canal
- Rigid pouchoscopy- limited views
- Flexible pouchoscopy with biopsies
- Bloods: FBC, U&Es, LFTs, Vitamin B_{12}, Vitamin D, Iron, Folate, Coeliac Ab screen

Other investigations

- Pouchogram/defaecating pouchogram
- MRI (magnetic resonance imaging)
- Small bowel follow through
- Ano-rectal physiology
- Stool sample
- SeHCAT test (7-day observation test with radiation)


Digital Examination
Stricture
Dilate + Hegar dilator
Medina catheter
Revisional surgery
Weak sphincter
Ano-rectal physiology & USS
'High' Anastomosis
Suspicion of retained anorectal mucosa (cuffitis)
No stricture
Ileo-pouchoscopy and biopsy
Pouchitis
See pouchitis algorithm
Pre-pouch ileitis
28days cipro & metronidazole[2]
Retained anorectal mucosa (cuffitis)
Treat as proctitis or
Revisional surgery
Pouch inlet/outlet stricture
Dilate or Revisional surgery
Defaecating pouchogram
Small volume pouch
Consider revisional surgery
Lifestyle advice
Functional outflow obstruction
Medina catheter
Biofeedback
MRI pelvis
Pelvic collection/ anastomotic leak
Appropriate surgery

What is pouchitis?

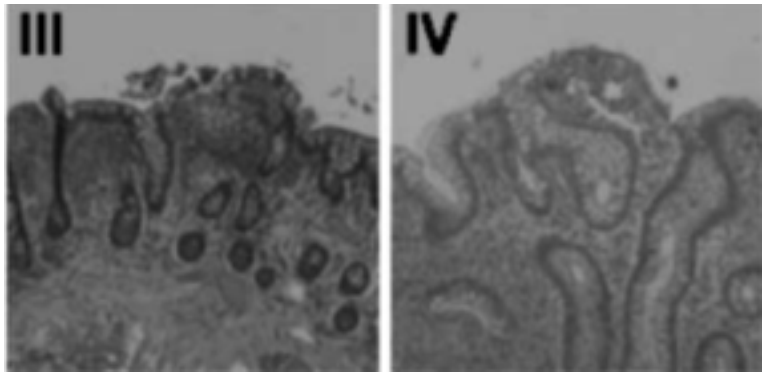
- Pouchitis is an inflammatory response to changes within the pouch, aetiology is unknown
- It is thought to be triggered by changes in the intra-luminal bacteria within the pouch
- 20-50% of patients will suffer from pouchitis at some time
  (Moskowitz et al 1986; Nassar et al 2006)

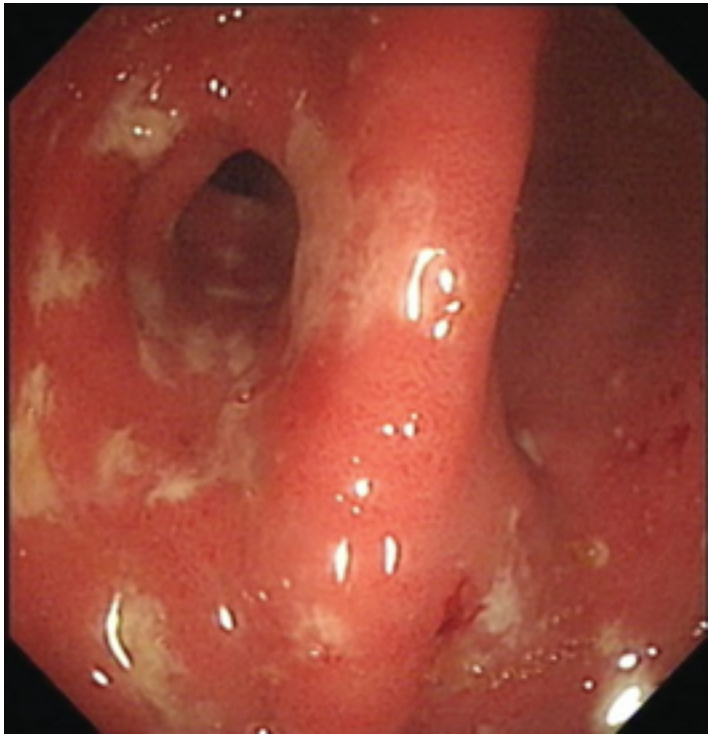
Pouchitis

Diagnosis based on:

- Compatible symptoms
- Endoscopy
- Histology

Clinical
- Stool frequency
- Faecal urgency or abdominal cramps
- Rectal bleeding
- Fever





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Classification of pouchitis

- Simple Pouchitis (Acute) one episode per year
  - antibiotic responsive

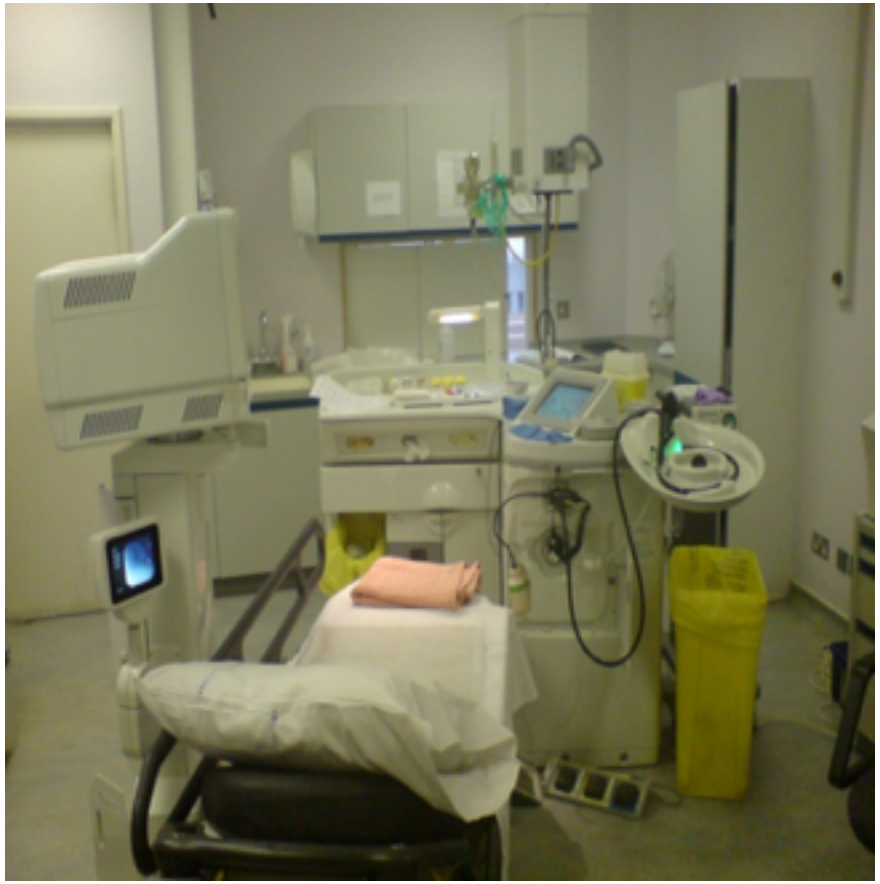
- Complex Pouchitis (Chronic)
  - (i) antibiotic responsive
  - (ii) antibiotic dependent
  - (iii) antibiotic resistant

Think pouchoscopy!

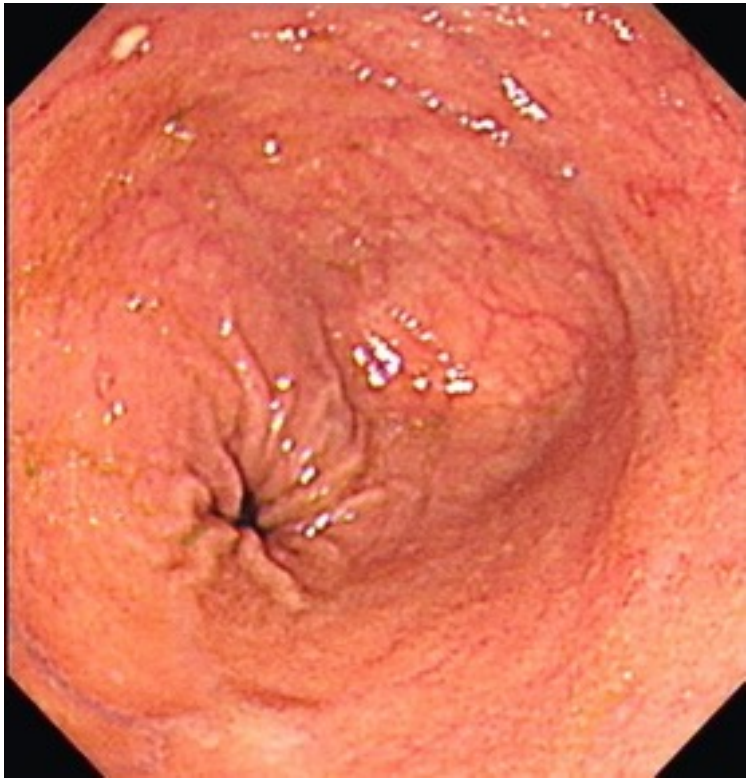
Best initial test to…..

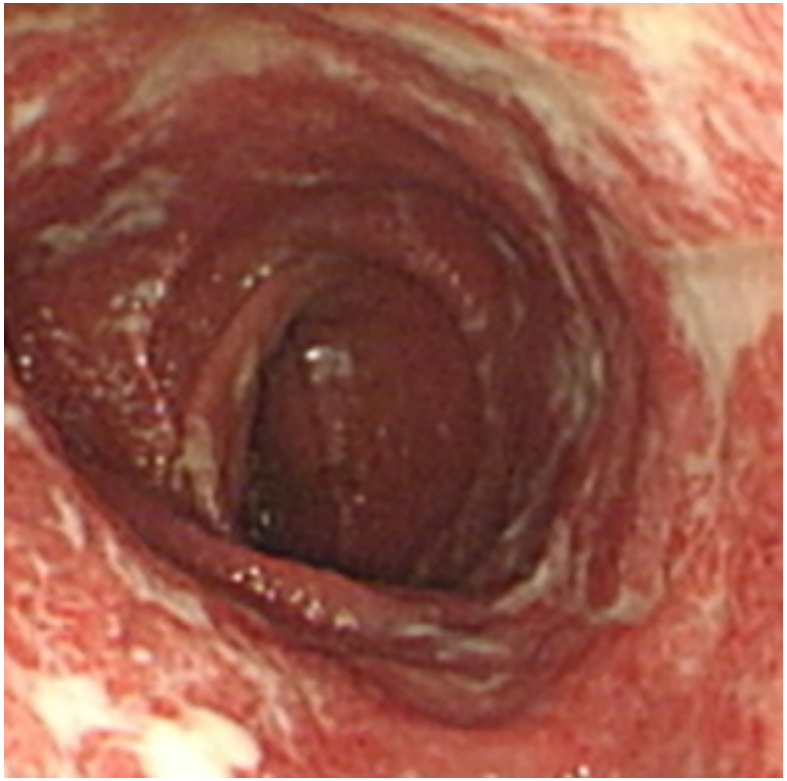
- Exclude or confirm pouchitis, cuffitis, pre-pouch ileitis, fistulae, strictures, neoplastic lesions, Crohn's disease

- Balloon dilate strictures



Endoscopic views





Treatment of pouchitis

Antibiotics

Probiotics

- 5×10^{11} per gram of viable lyophilized bacteria of 4 strains of lactobacilli, 3 strains of bifidobacteria, and 1 strain of *Streptococcus salivarius* subsp. *Thermophilus*

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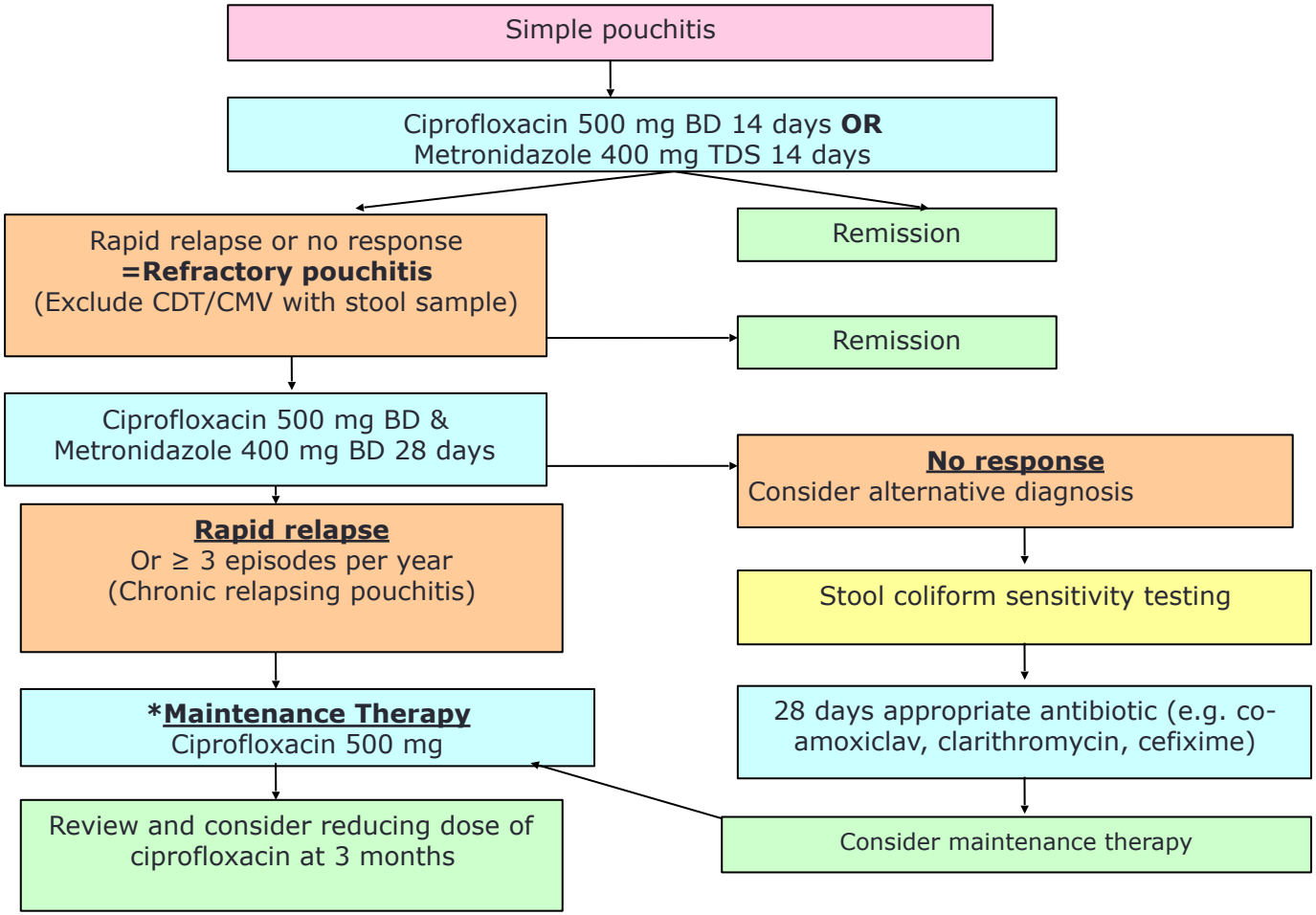

*** Maintenance therapy consider probiotic VSL#3** 4 UK sachets daily, if mucosa normal at repeat pouchoscopy. Benefits have been described in some pouch patients with pouchitis.

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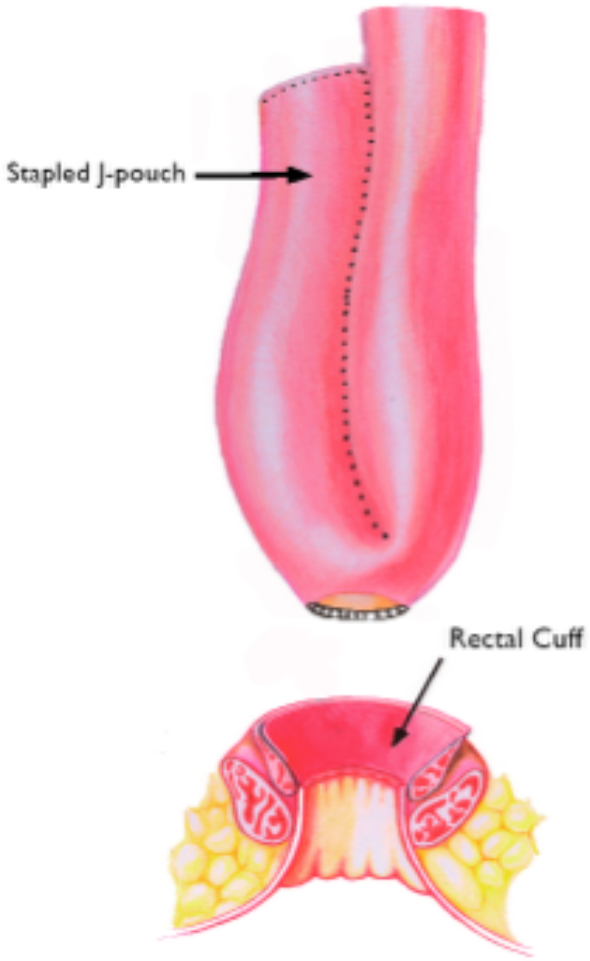
Cuffitis

- Inflammation in the cuff above the anal transition zone
- Symptoms similar to proctitis – burning, frequency and bloody stool



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Treatment of cuffitis

- Mesalazine suppositories 500mg BD for 6 weeks
- Predsol suppositories 5mg BD for 6 weeks
- Pouch revision surgery

Strictures

- Develop above, in or below pouch
- Most commonly at anal anastomosis
- Patients taught how to use Hegar dilator

HOW TO USE A HEGAR DILATOR

(available on prescription)

EQUIPMENT NEEDED:

1. Hegar dilator or St Mark's dilator
2. Lubricating jelly (available from your GP), Lidocaine gel 2% (St Mark's formula), or instilligel (available from your GP)

INSTRUCTIONS FOR USE:

1. Empty the pouch before using the dilator
2. Lubricate the end of the dilator with the jelly
3. Lie on your left side with your knees drawn up to your chest.
4. Gently insert dilator into the anus about 3-6cm.
5. Your doctor or pouch nurse can show you how far you need to insert the dilator by gently inserting a finger into the anus and feeling the anastamosis (or the join which may have narrowed)
6. Rotate the dilator 360 degrees and then gently remove
7. Your doctor or pouch nurse will advise you on how frequently this needs to be done. Usually this only needs to be done once a day.
8. After use, the dilator should be cleaned in hot soapy water, dried and stored in a safe place

IT IS IMPORTANT TO DILATE REGULARLY EVEN IF YOU FEEL SLIGHTLY UNCOMFORTABLE DURING THE PROCESS. EFFECTIVE DILATION MAY PREVENT THE NARROWING IN YOUR ANASTAMOSIS REOCCURING.

Reference: Williams (2002) The Essentials of Pouch Care Nursing

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Functional disorders

- Usually a late complication
- Difficult to manage
- Varying degrees of dysfunction
- Defaecating pouchogram
- Use of medina

HOW TO USE A MEDINA CATHETER

Dispensed by Astra Tech. Tel: 01453 791763 (Code M8730-5)

EQUIPMENT NEEDED:

1. Medina catheter
2. Lubricating jelly (available from your GP), Lidocaine gel 2% (St Mark's formula), or instillagel (available from your GP)
3. Syringe

INSTRUCTIONS FOR USE:

1. Fill the syringe with 20-30mls of warm tap water
2. Lubricate the 'eyelet' (end) of the medina with the lubricating jelly
3. Hold the medina catheter between the thumb and forefinger about 3-4" from the eyelet end
4. Gently insert the catheter into the anus until your fingers touch your buttocks
5. Ensure the other end of the catheter is aimed towards the toilet
6. Once the catheter has been inserted into the anus the pouch should drain faecal fluid or flatus
7. Ensure the pouch is empty by wiggling your hips, gently massaging your abdomen, coughing or standing slightly from the toilet
8. If the consistency of the faecal matter is too thick, then attach the syringe to the end of the catheter and insert a little water, to aid drainage.
9. After the pouch has been emptied remove the catheter slowly. Try to relax as this will assist removal. If the catheter becomes stuck, **do not panic**. Gently rotate catheter if possible or insert a little water as you pull downwards.
10. After use, wash in hot, soapy water, dry and store in a safe place.

Reference: Williams (2002) The Essentials of Pouch Care Nursing pg 162

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Nursing management at St Mark's Hospital

- 1 Lead Nurse Practitioner and 2 Pouch Nurse Specialists
- Nurse led clinics – once a week and rapid access clinics
- Joint Consultant clinics
- Monthly research meetings
- MDT complex cases meeting
- Dedicated telephone advice line and email access

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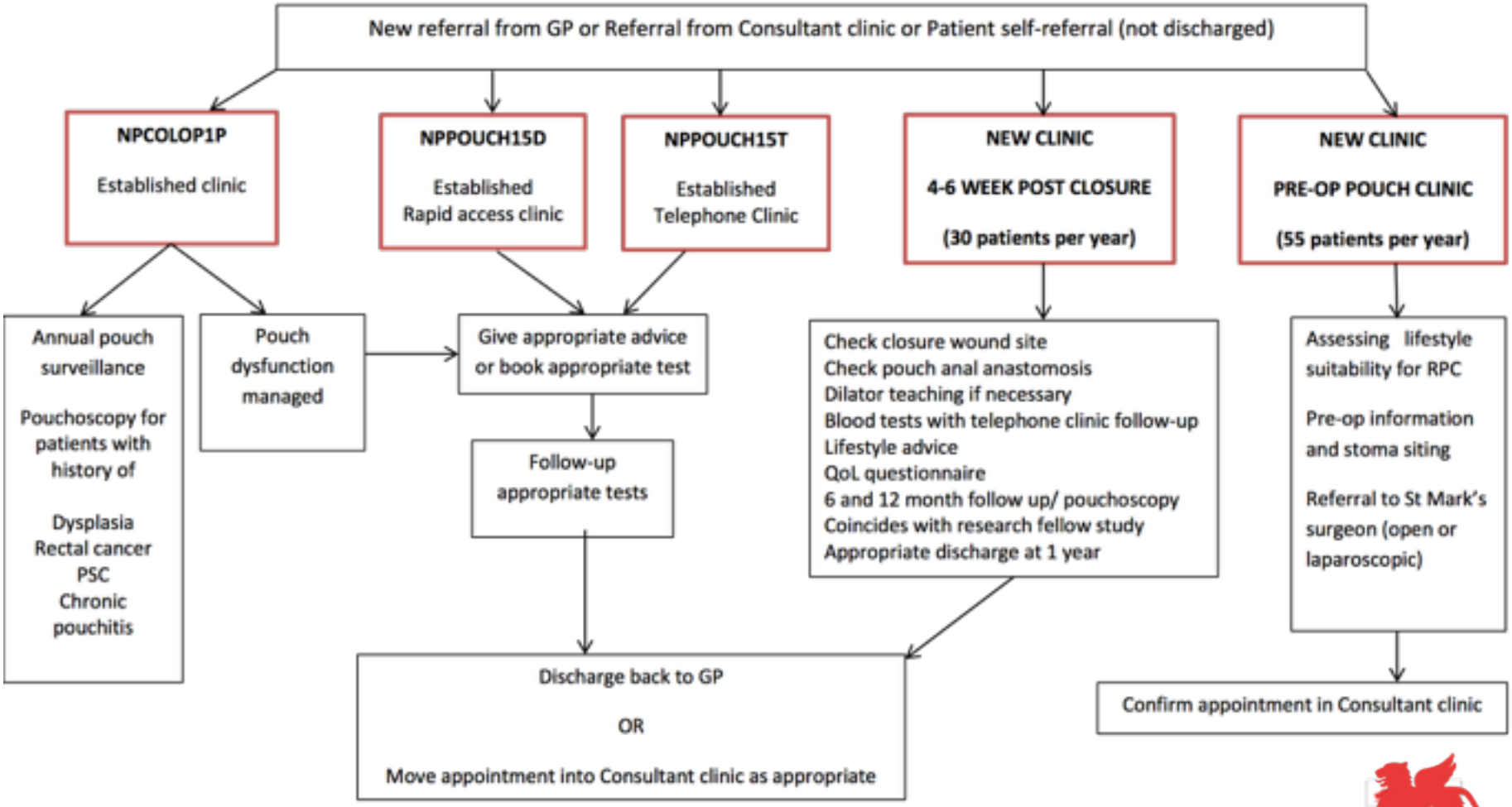
OUTPATIENT NURSE–LED POUCH SERVICE PROTOCOL (2013-14)



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Role of the nurse practitioner/specialist

- Early introduction to patient and reassurance of long-term point of contact
- Realistic expectations of pouch function and lifestyle (written information)
- Comprehensive understanding of the process and stoma care- differentiate between end and loop stoma
- Introduce an established patient with similar background
- Assess psychological, physical, spiritual, religious, cultural and socio-economic needs
- Patients informed as to what will happen post-operatively/stoma care

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Patient information

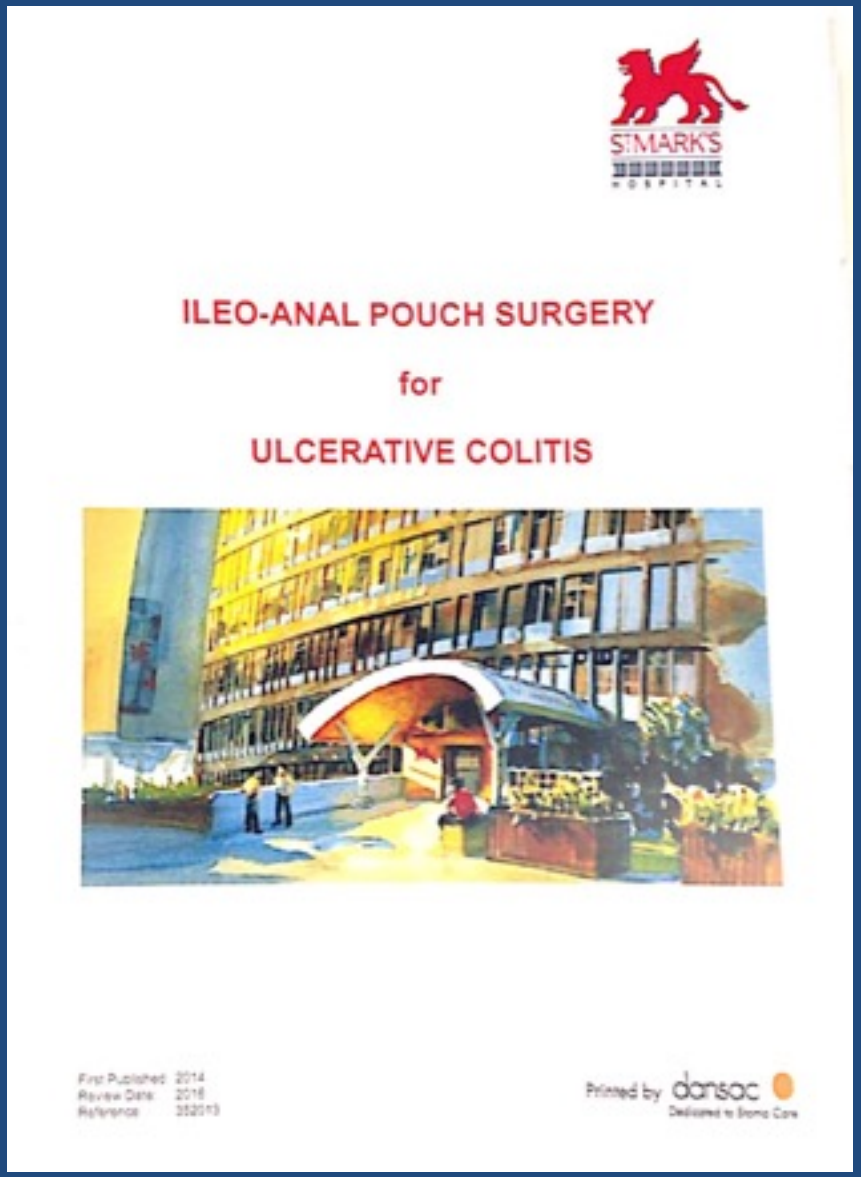
The North West London Hospitals NHS

Having a pouch
- pros and cons

For some people, an ileoanal pouch is the best solution to certain chronic bowel conditions, but it is not without drawbacks. Zarah Perry-Woodford explains

Zarah Perry-Woodford
RGN DipN Clinical Nurse Specialist Pouch Care,
St Mark's Hospital, London

Pouch surgery is an elective procedure and patients have time to research their options before making a decision



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ILEO-ANAL POUCH SURGERY

for

ULCERATIVE COLITIS

First Published 2014
Review Date 2016
Reference 352013

Printed by dansac
Dedicated to Stoma Care

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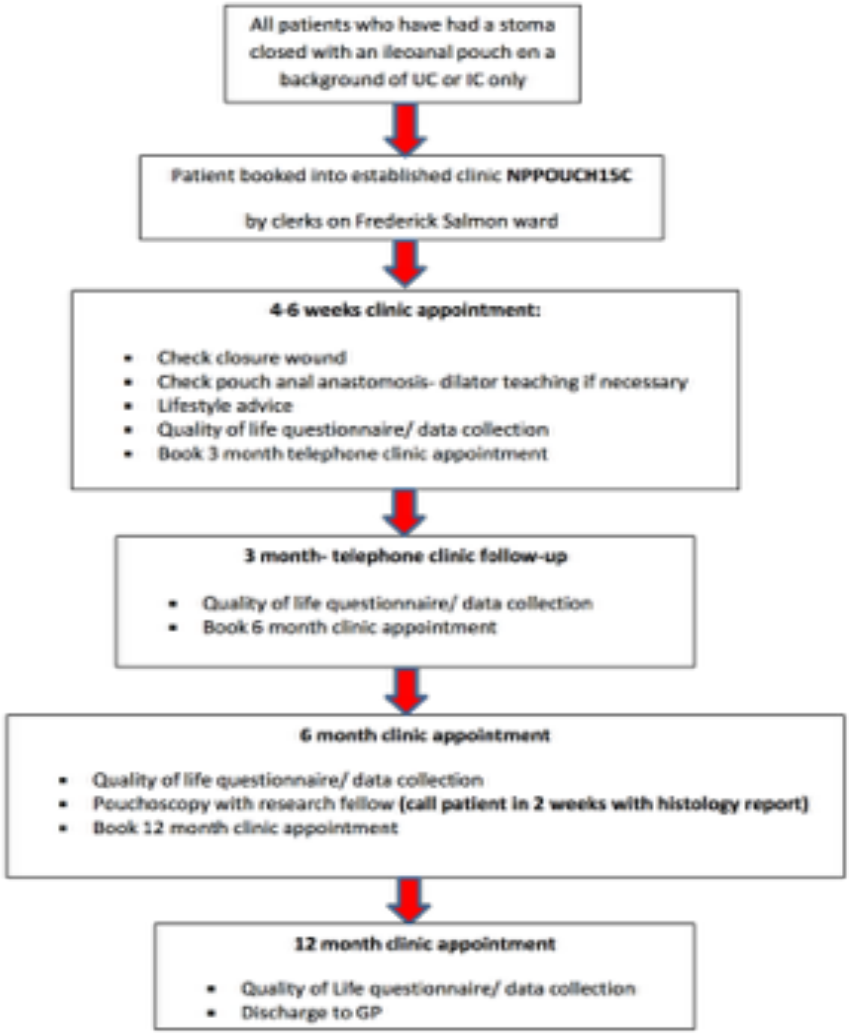
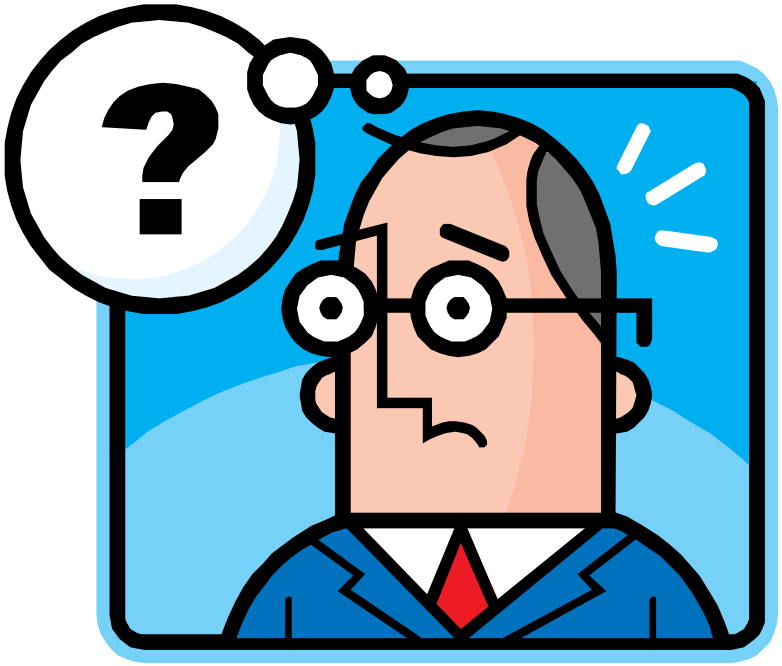
PROTOCOL FOR NEW 4-6 WEEK STOMA CLOSURE CLINIC

OUTPATIENT NURSE–LED POUCH FOLLOW-UP



Managing expectations

- Loose stool initially
- Regular toileting – don't fixate on numbers
- Vital peri-anal skin care – regular use barrier wipes and cream
- Ability to defer defaecation
- None/minimal faecal leakage in the day
- Seepage may occur at night
- 6-18 months 'settling' period
- Dietary considerations
- Support from the pouch team



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Early (expected) pouch problems

- Perianal soreness
- Anal itch or burning (pruitus ani)
- Nocturnal leakage/seepage
- Frequency
- Ineffective emptying
- Fatigue

- Feelings of isolation
- Lack of knowledge

Urge resistance and pouch compliance

- Training to improve pouch capacity and behavioural response
- Requires education of pouch positive bowel anatomy
- Understanding of continence mechanisms
- Insight into brain/bowel signals

Correct position for opening your bowels

Step one

Knees higher than hips

Step two

Lean forwards and put elbows on your knees

Step three

Bulge out your abdomen
Straighten your spine

Correct position

Knees higher than hips
Lean forwards and put elbows on your knees
Bulge out your abdomen
Straighten your spine

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People with pouches will not have a ‘normal’ bowel pattern but with guidance can find their unique pouch pattern

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Summary

- Ileoanal pouches are the ‘gold standard’ surgical option for patients with UC
- Most patients have a satisfactory quality of life
- Not all causes of pouch dysfunction are due to pouchitis - there are a range of complications with similar outcomes
- Pouch function is subjective and is highly dependent on patient concordance and support from medical and nursing teams

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Pouch team….. Zarah, Lisa & Sam

Pouch team…..Lisa, Zarah & Sam