End-ileostomy

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An end-ileostomy is formed after a colectomy without anas - tomosis, when it may later be reversed, or after panproctocol - ectomy , when it is permanent. The ileum is normally brought through the rectus abdominis muscle. Careful attention should be paid to the terminal ileal mesentery to ensure tha t it is not too bulky . The use of a spout was originally described by Brooke; this should project some 2–4 /uni00A0 cm from the skin surface (Figure 74.7). A disposable appliance is placed over the ileos - - tomy so that it is a snug fit at skin level. There may be an ‘ileostomy flux’ while the ileum adapts to the loss of the colon. While ileostomy output can amount to 4–5 litres per day , losses of 1–2 litres are more common. A con - sistent ileostomy output in excess of 1.5 litres is usually asso - ciated with dehy dration and sodium depletion in the absence of intravenous therapy . Up to 20% of patients may require readmission for the trea tment of dehydration after creation of an ileostomy but the stools thicken in a few weeks and are usu ally semisolid in a few months. The help, skill and advice of the stoma care nurse specialist are essential. Modern appliances are unusual have transformed stoma care and skin problems (Figure 74.8). Complications of an ileostomy include prolapse, retraction, stenosis, bleeding, fistula and parastomal hernia.

Figure 74.7 Construction of an end-ileostomy. The diagram is orientated such that the upper aspect of the stoma is to the right, thus when the sutures are tied the everted stoma is angled slightly inferiorly. (Reproduced with permission from O’Connell PR, Madoff RD, Solomon MJ (eds). Operative surgery of the colon rectum and anus , 6th edn. Boca Raton, FL: CRC Press, 2015.)

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