



Adapted Crusting Technique in Children with Peristomal skin dermatitis

Nilubon Tanvaropas, RN, ET, Sunantisa Wonglawan, RN, ET
Queen Sirikit National Institute of Child Health

Background

The peristomal skin is the skin right around the stoma. It's the skin that the ostomy wafer adheres to. In children, the area of peristomal skin is approximately 2 x 2 inches around the stoma. People with ileostomies have the most skin complications, followed by people with urostomies and colostomies respectively. Most peristomal skin complications (77%) are related to the stoma effluent (or output) coming in contact with and sitting on the skin.

Peristomal dermatitis is most often caused by stool or urine that is an irritant to the skin. The amount of exposure as well as character of effluent will determine extent of peristomal irritation. Stool leaking on the skin causes inflammation. The extent of this irritant dermatitis can vary with small bowel output being caustic enough to produce skin erosion. The prevention of any dermatitis is the primary focus in the early days and weeks after a new ostomy formation. Any degree of dermatitis will inhibit pouch adhesion, which then leads to more leakage and skin inflammation. Consequently, a painful dermatitis develops that is challenging to manage. This can be particularly distressing to a new patient as he or she adjusts to the presence of a stoma as well as their disease process. Prevention of this dermatitis leads to a much better outcome and a happier patient

Case study

2 years 8 months Myanmar boy with Imperforate anus (high type) and rectourethral fistula S/P sigmoid colostomy, admission for closure of colostomy at pediatric surgery ward. Stoma assessment, type of colostomy is sigmoid colostomy at RLQ, pink and moist, oval shape width 3.1 cm length 4.2 cm, stoma height prolapsed, opening of lumen is lateral, mucocutaneous suture line intact, peristomal skin has lesion level 1 (hyperemic lesion TV 100%). The sac instrument assessment, type of lesion: L1 (hyperemic lesion), topographical location: TV (All quadrants), sac assessment: L1TV, effluent color yellow and semisolid, pain frequency at pouching.

Method

We used the following materials of wound care and IAD management. How to make;

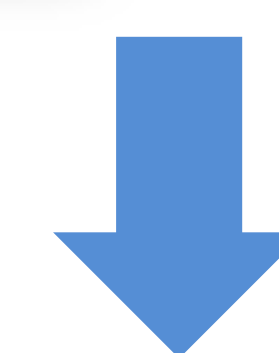
1. Dressing with 0.9% NaCl
 2. Dry the skin area
 3. Crusting technique followed by spreading stoma powder on the skin around stoma and site of irritation. Then sealing the powder in with a layer of skin barrier 3 cycles
 4. Pouching with one-piece
- ❖ Change pouching every 2 days or leakage

Results

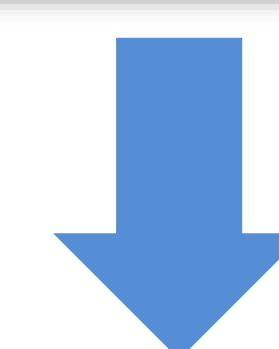
Day1



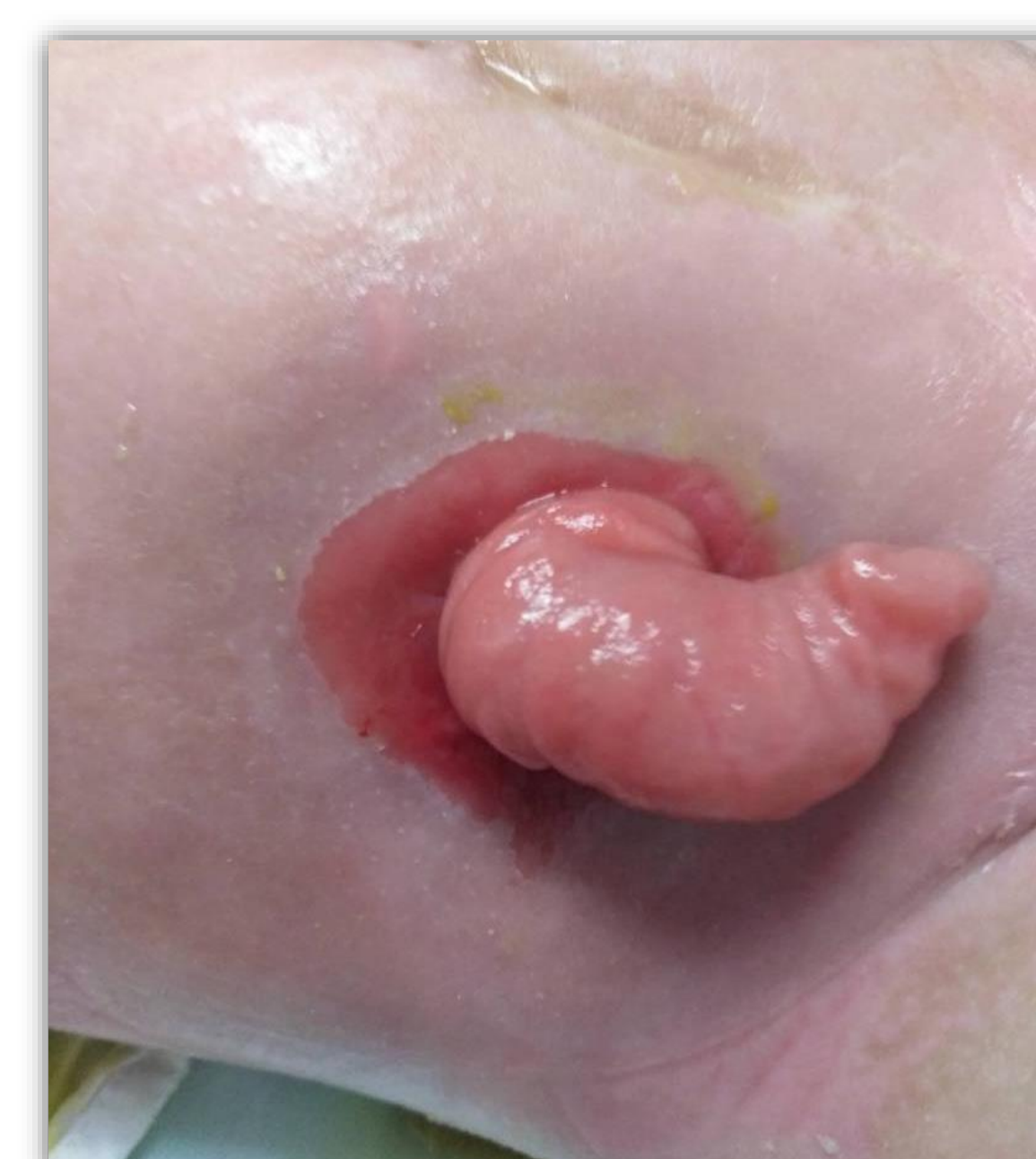
Day1



Day3



Day5



Conclusions

Crusting technique and pouching especially the adapted crusting technique was effective in the treatment of children with peristomal skin dermatitis. This technique may be beneficial to other child and organizational outcomes such as improving safety of care, decreasing pain and discomfort, reducing nursing workload and hospital cost, and improving quality of life. Peristomal skin is well, from L1 (100%) TV to L1 (10%) TV. The surgeons set operation for closure of colostomy at day 6. No post-operative complication. The patient was discharge at day 14.

References

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2. Yvonne B. (2010). Understanding the challenges and management of paediatric stomas. *Gastrointestinal nursing*, 8(6): 38-42.
3. Robatmily A, Anboohi Z, Shinabadi FA, Nasiri M. (2018). Effect of Providing Ostomy Care Education to Mothers of Neonates with Peristomal skin Complications. *Advances in Nursing and Midwifery* 2018, 27(4): 6-10.