A More Functional Loop Ileostomy Rod

Elsa T. Goldstein, M.D., Paul R. Williamson, M.D.

From the Department of Colon and Rectal Surgery, Orlando Regional Medical Center, Orlando, Florida

The use of a flat Jackson-Pratt drain for a loop ileostomy rod is described. It elevates the loop, prevents its retraction into the abdomen, and can be cut to precisely the size of the stoma, thereby alleviating the problem of skin excoriation from a poorly fitting appliance. [Key words: Ileostomy; Ulcerative colitis; Stoma; Loop ileostomy; Surgical technique]

Goldstein ET, Williamson PR. A more functional loop ileostomy rod. Dis Colon Rectum 1993;36:297–298.

The loop ileostomy is enjoying a resurgence in popularity owing to its utilization for diversion of the ileoanal pouch. Most authors consider diversion for this operation mandatory,[1] while others now advocate a selective approach.[2, 3] A loop ileostomy has the advantages over an end ileostomy of being easy to perform and easy to take down. However, a disadvantage it has in the immediate postoperative period is the difficulty in fitting an appliance around the rod that is placed beneath the loop. Moreover, stoma retraction is a significant complication of loop ileostomy, which may lead to incomplete diversion.[4]

Various rods are commercially available, but they are all much longer than the width of the stoma, and they cannot be cut. The disparity in size does not allow the appliance to be applied to the mucocutaneous junction. Therefore, skin excoriation from ileal content can be a problem.

A technique for making a "custom-fit" ileostomy rod is described.

TECHNIQUE

A right lower quadrant muscle-splitting incision through the rectus is made. The loop of ileum is chosen, a Penrose drain is placed through a mesenteric defect created under it, and the Penrose drain is used to pull the loop through the incision. The end of a flat, 10-mm, silicone Jackson-Pratt drain (Fig. 1) (Snyder Hemovac; Zimmer, Dover, OH) is cut off and brought under the loop, and the Penrose drain is removed (Fig. 2). The piece of drain can be trimmed to the width of the loop. The drain has numerous precut holes in it that can be used to suture it to the skin (Fig. 3). Alternatively, it can be stapled to the skin by cutting off the anterior half of the drain end to create a "tab."

The remaining Jackson-Pratt drain is placed in the pelvis, the abdomen is closed, and the ileostomy is matured. Now an appliance can be cut precisely to fit around the mucocutaneous junction.

The Jackson-Pratt drain functions well in elevating the stoma above skin level. Since there is no problem with appliance placement, this "rod" may be either removed at a postoperative visit or left in place until ileostomy closure.

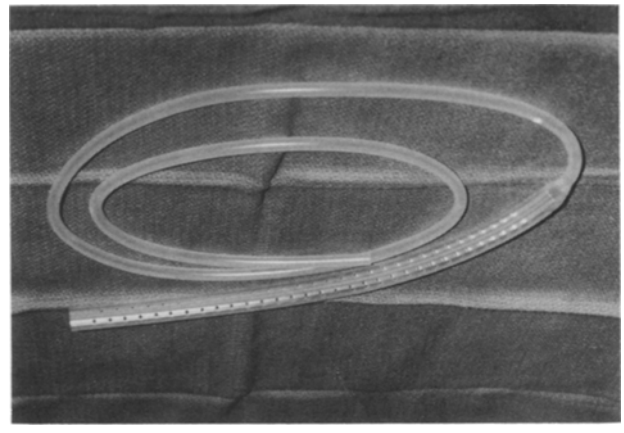

Figure 1. A flat, 10-mm Jackson-Pratt drain is used.

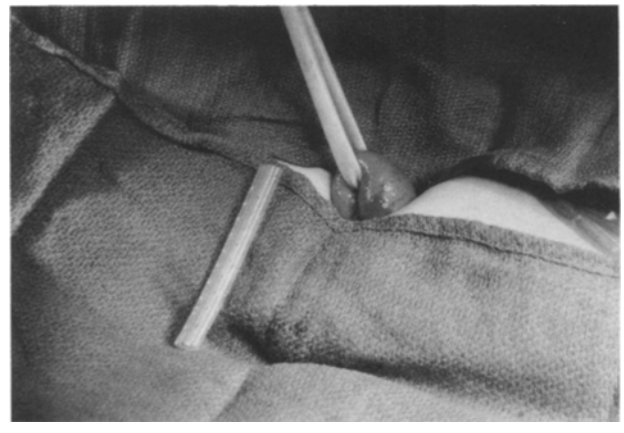

Figure 2. The loop of ileum is brought through the incision by a Penrose drain. A piece of the Jackson-Pratt drain is at the lower left.

Address reprint requests to Dr. Williamson: Colon and Rectal Clinic, 110 West Underwood Street, Orlando, Florida 32806.

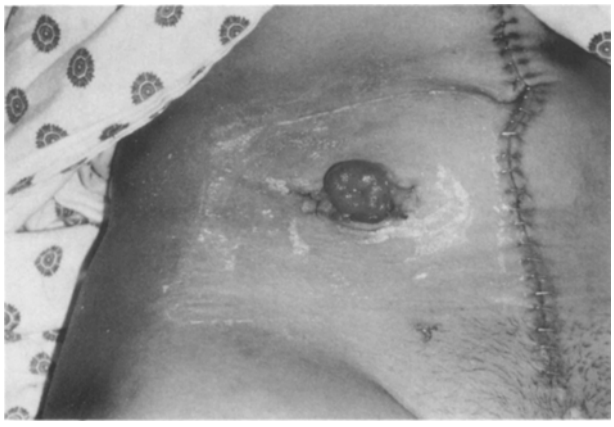

Figure 3. Rod trimmed and sutured to skin.

This technique offers three advantages over conventional rod placement. First, the Jackson-Pratt drain can be cut to the needed size for better appliance placement. Second, it can be left in place indefinitely, preventing stoma retraction. Third, the cases for which a loop ileostomy is utilized almost always require a drain. Therefore, cutting a little piece off the end of a drain does not incur any additional expense.

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