



Service Priorities and Programmes Electronic Presentations

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A Non-Surgical Means of Fecal Diversion - Fecal Management System

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Non-Surgical Means of Fecal Diversion

Introduction

Patients with perineal injuries often required debridement and perform grafts or flaps reconstruction later after wound progress well. Fecal contamination of this area can prevent wound healing and cause sepsis. Insertion of rectal tube or use of Foley catheter to divert feces has been known to cause rectal perforation, fistulas or ineffective diversion. Pouching system is often useless for wounds around perineal area. Therefore, patients with poor bowel control always required stoma formation. Fecal management system consists of a flexible silicone tube with a soft silicone catheter at one end which can be inserted into patient's rectum and held in place by a low pressure retention balloon. The other end attaches a collection bag to collect loose feces drained out. This special device is used for diverting liquid or loose stool to reduce soiling, preserve skin integrity and prevent fecal contamination of perineal wounds. The device can be kept in the rectum for up to 30 days and is indicated for patients with little or no bowel control. Advantages

1. Reduce contamination of linen or perineal wound dressing
2. Reduce nursing time spent on changing of linen or napkin
3. Decrease unpleasant odour associated with fecal incontinence
4. Prevent fecal contamination of perineal wound
5. Facilitate fecal fluid monitoring
6. Improve skin integrity
7. Improve patient dignity

Objectives

To evaluate the effectiveness of fecal management system in prevention of perineal wound contamination.

Methodology

A retrospective review of nursing notes was conducted on 3 patients with perineal wound managed by fecal management system; in view of fecal contamination of wound and frequency of dressing changed

Result

RESULT 4 fecal tubes were inserted in 3 patients with perineal wounds. They were suffered from ischioanal abscess, scrotal and perineal abscess and Fournier's gangrene. They all have moderate to severe fecal incontinence due to peri-anal tissue involvement. The average length of use was from 9 days to 5 weeks with mean 18.5 days. Patient A – Fecal contamination was nil to minimal (contaminated the gauze around the tube only) with wound dressing changed 16 times within 5 weeks (average

dressing changed was 2.4 days). Patient B and C –No fecal contamination with wound dressing changed routine daily. OUTCOME All three patients were free from fecal contamination of perineal wounds with good wound progress. Wound closure was performed 10 days to 6 weeks later without stoma formation. CONCLUSION Large perineal or perianal wound always required a stoma for fecal diversion in order to keep the wound clean and free from infection. The fecal management tube allows diversion of feces away from the perineum to enhance wound healing. It is safe, effective and may help to avoid stoma formation for these patients.