

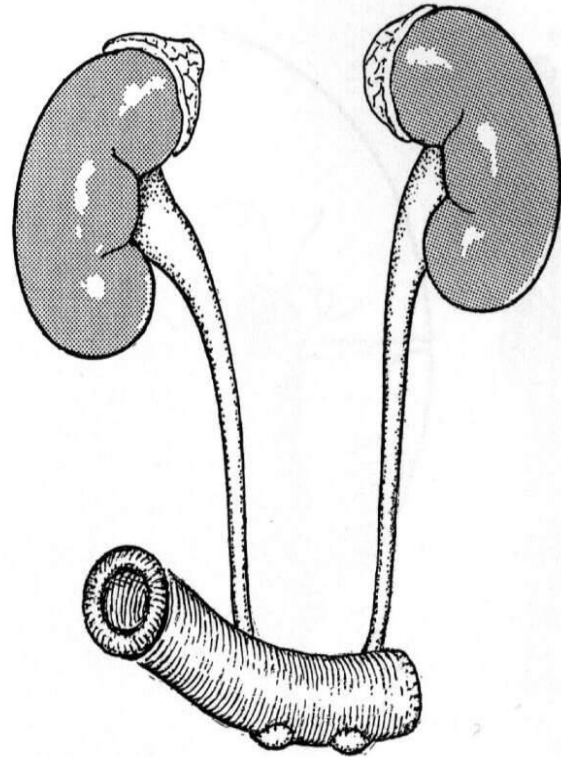
Profilo corporeo e rimodellamento stomale: valutazione e esiti nella chirurgia urologica



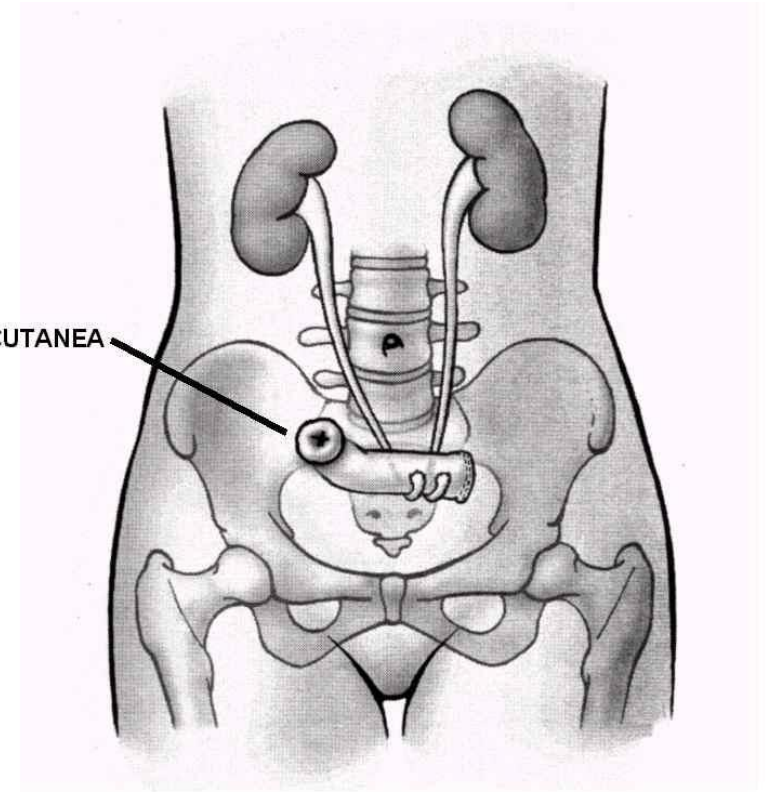
Massimo Iafrate
Clinica Urologica
Università degli Studi di Padova



Condotto ileale sec. Bricker



STOMIA CUTANEA



1950

Condotto ileale sec. Bricker



BLADDER SUBSTITUTION AFTER PELVIC EVISCERATION

EUGENE M. BRICKER, M.D., F.A.C.S.*

THE problem of developing a suitable substitute for the urinary bladder has been one that has intrigued surgeons intermittently for a good many years. Practically all anatomical possibilities were exhausted at the beginning of this century. Hinman and Weyrauch¹ have reviewed the various attempts at bladder substitution by uretero-enterostomy. Apparently the first attempt to divert the urinary stream into an isolated segment of ileum and ascending colon was done by Verhoogen² in 1908. Such attempts were subsequently discarded because of the prohibitive mortality and the problem of ureteral disposal following cystectomy was solved for many years by the simple implantation of the ureters into the intact sigmoid colon. This procedure is still the one of choice following cystectomy and it will probably remain the procedure of choice in cases in which the sigmoid and rectum can be preserved. However, the recent development of pelvic evisceration as a therapeutic procedure has focused attention again on the problem of what to do with the ureters in cases in which this procedure is used, since the sigmoid colon and rectum are not available as a receptacle.

Condotto ileale sec. Bricker

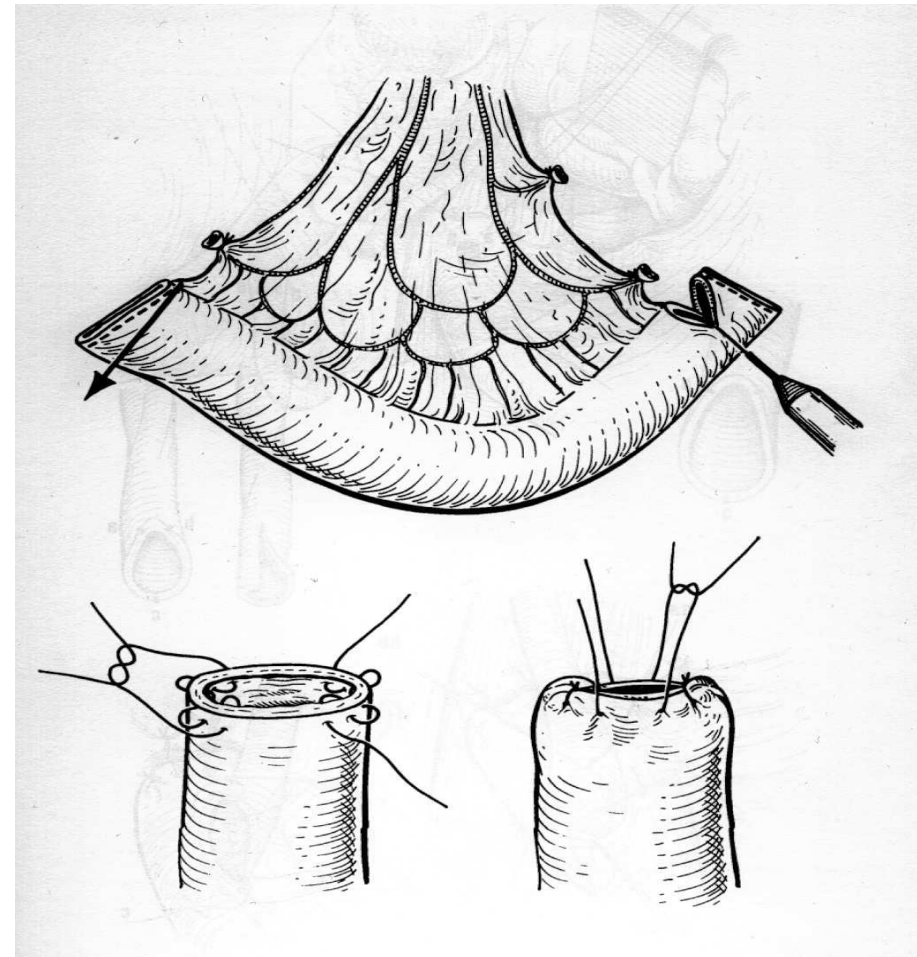
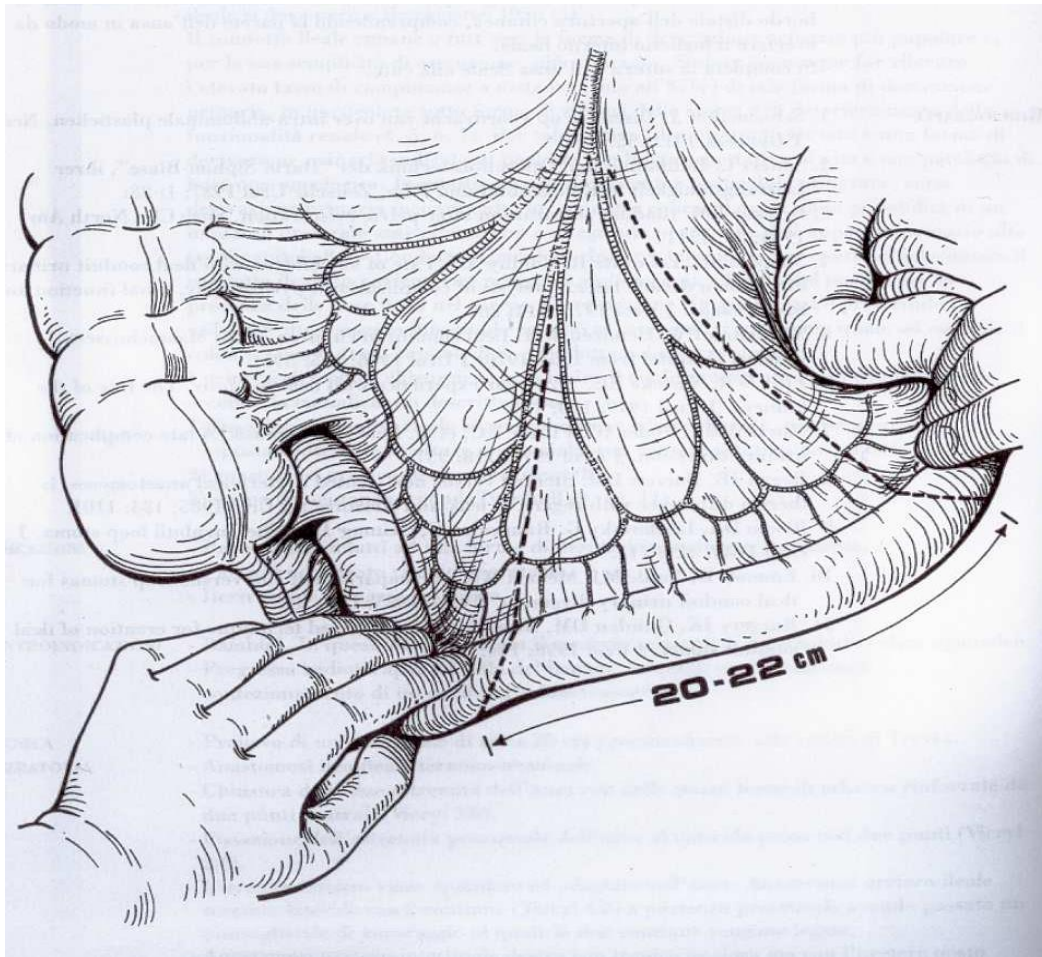
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EUGENE M. BRICKER

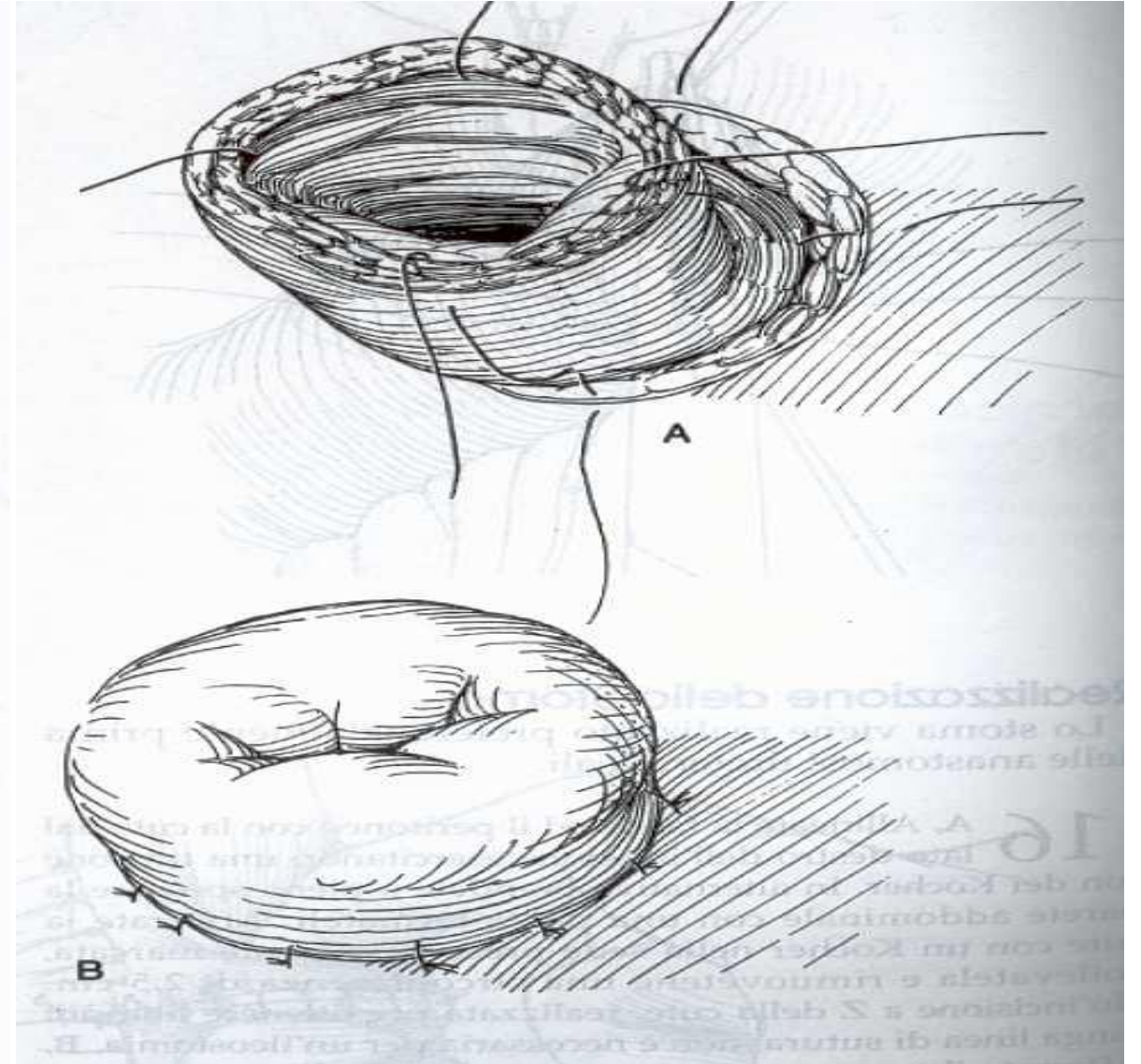
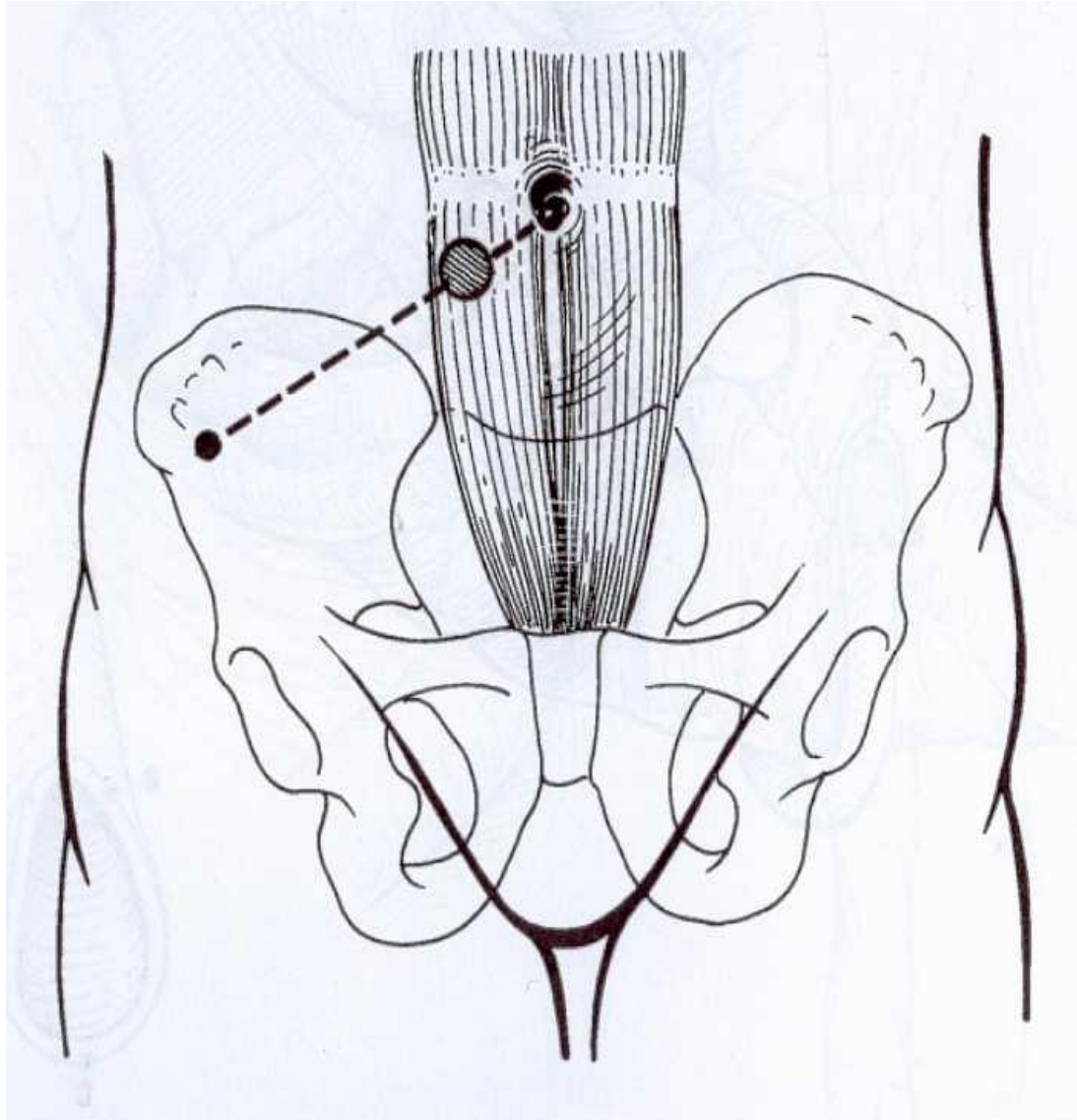


and after complete hemostasis is obtained, the bladder substitution procedure is done. The details of this procedure are depicted in accompanying illustrations (Figs. 436, 437 and 438). It consists essentially of isolation of a segment of terminal ileum about 4 or 5 inches from the ileocecal junction and about 6 to 8 inches in length. The continuity of the gastrointestinal tract is reestablished by end-to-end anastomosis of the ileum, the proximal end of the isolated segment is closed and the distal end is prepared for deliverance through an opening in the right side of the abdomen, the site of which has been selected prior to opening the abdomen. This site must be optimum for the application of a Rutzen bag. The ureters are then anastomosed to the segment of ileum by the technic illustrated, the distal end of the segment is delivered through the accessory opening in the right side of the abdomen and the right lumbar gutter is completely obliterated as shown. We believe that obliteration of the lumbar gutter and suture of the segment of ileum in such a manner that the bowel cannot herniate lateral to it is an important step in the procedure. The abdominal stoma is immediately opened and the mucosa of the exteriorized ileum is carefully sutured to the skin with interrupted fine catgut sutures. A catheter is inserted through the

Condotto ileale



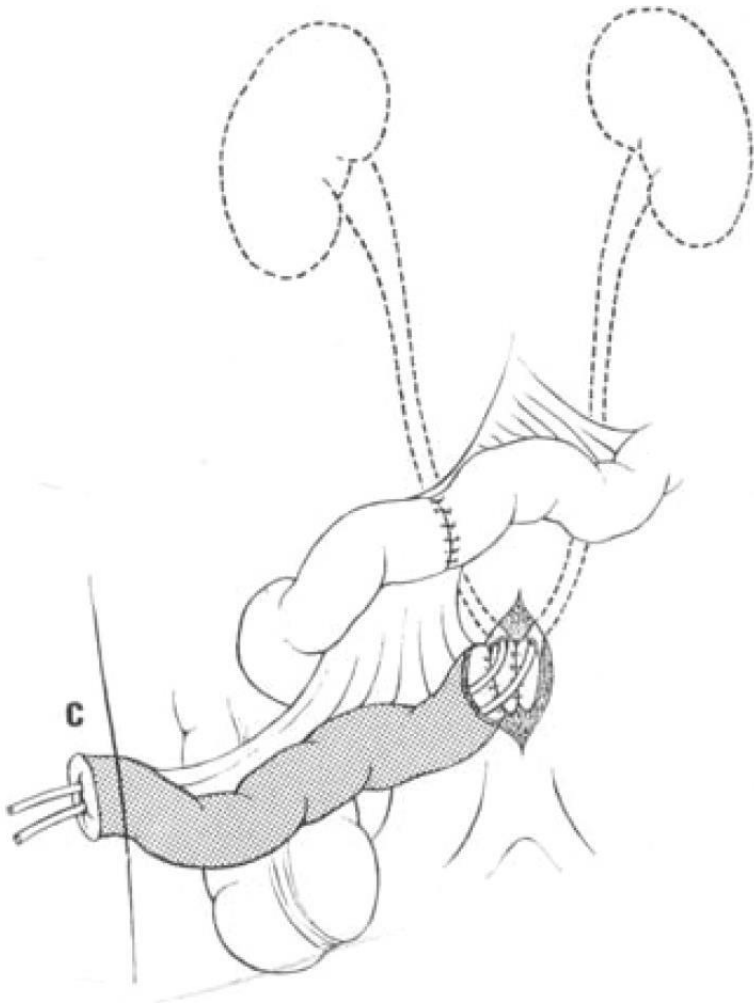
Stomia



URETERIC DIVERSION USING A CONDUIT : A SIMPLIFIED TECHNIQUE

By D. M. WALLACE, M.S.

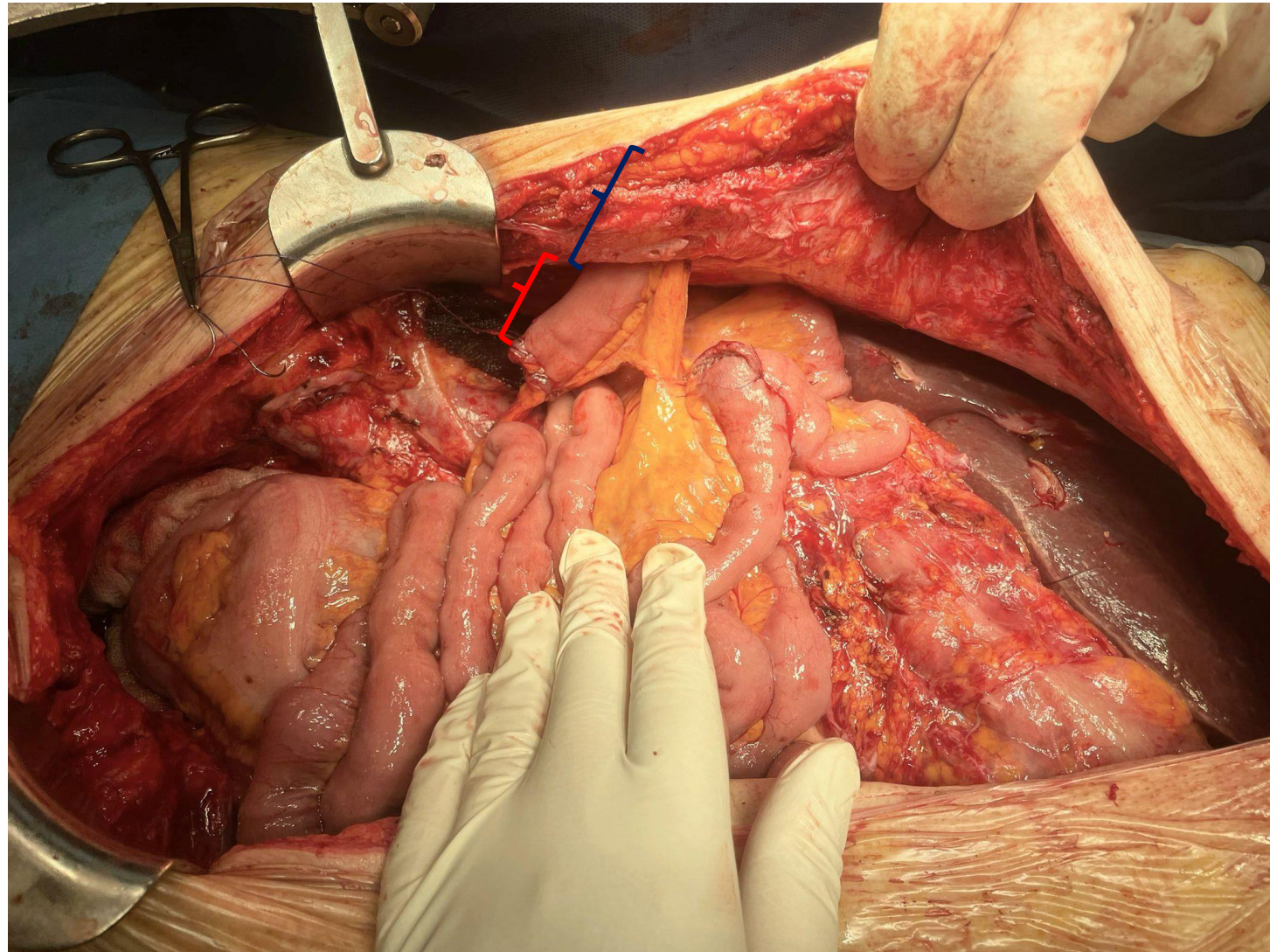
Royal Marsden Hospital, London



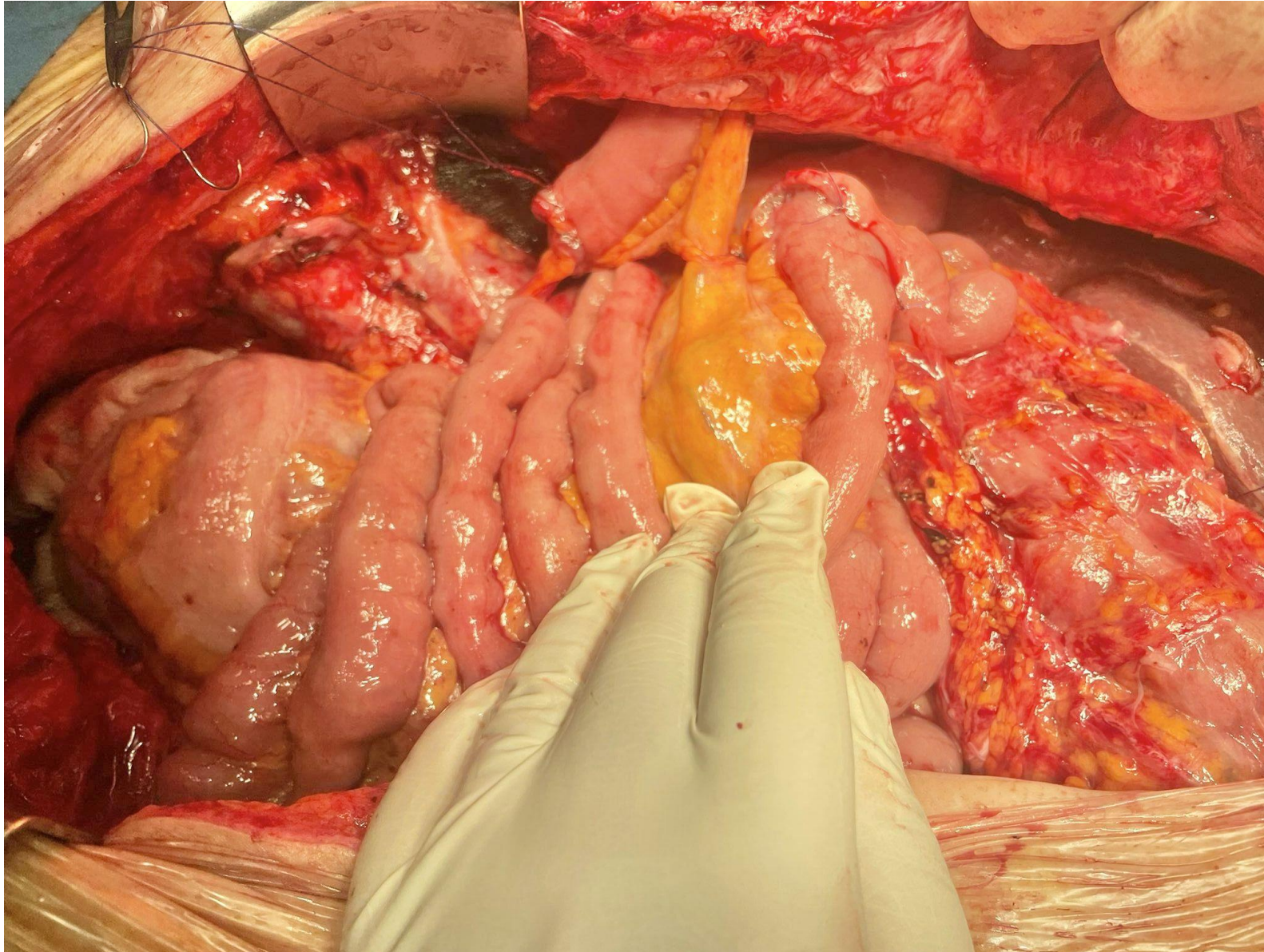
The positioning of the stoma demands meticulous attention. If placed too low, the skin crease in the groin will result in leakage, or in a pendulous abdomen the skin crease below the abdominal apron will also cause leakage. If the stoma is level with the iliac spine the belt will ride up and the flange pull on the stoma. If placed too near the umbilicus or an abdominal scar, leakage will be inevitable. Ideally, the patient should be fitted with whatever appliance is envisaged before operation so that the stoma site can be selected.

The care of the skin around the stoma requires constant attention. A dermatitis due to the appliance being too big and consequent pooling of urine around the stoma can be prevented by better choice of flange or by packing placed around the stoma to prevent accumulation of urine. The care of the flange and the method of adhesion is equally important ; some patients develop a sensitivity to adhesives, others prefer to have a flange which is watertight, but does not employ adhesives. Unless the urologist is prepared to take an interest in the after-care of the urinary stoma a certain number of his patients will find this an extremely unsatisfactory method of diversion.

Derivazione urinaria esterna «open»



Derivazione urinaria esterna «open»



Stomia dopo tecnica «open»



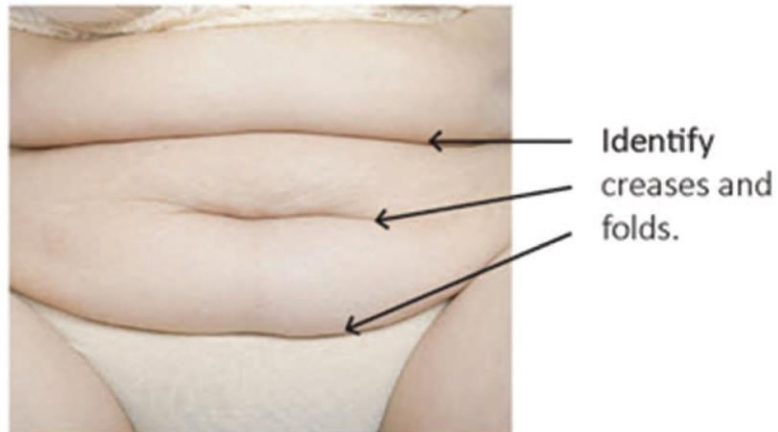
Step 1

Look at the profile of the patient. Notice where the abdomen curves back under toward the body. The underside of the abdomen is not visible to the patient. Avoid this area.



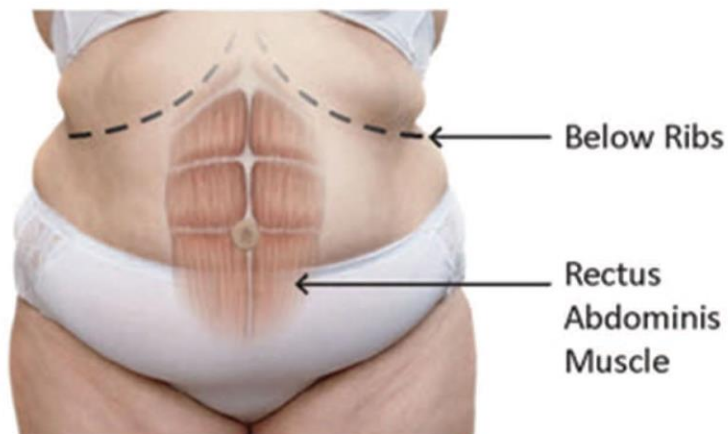
Step 2

While patient is seated, look for skin folds and creases. Note and avoid skin folds and creases.



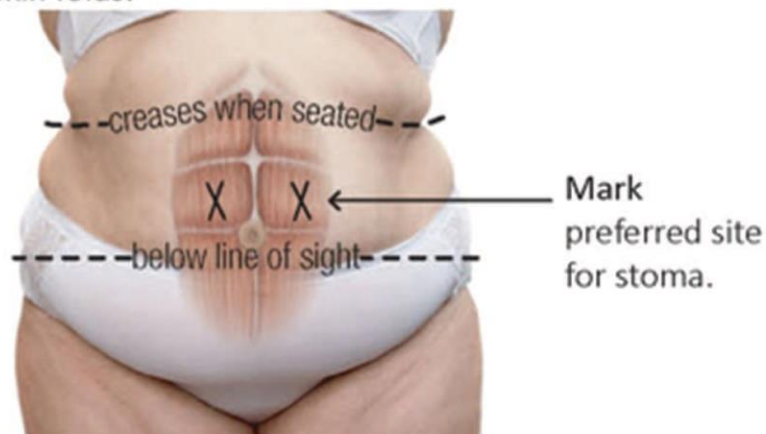
Step 3

Identify and target the rectus abdominis muscle below the ribs.

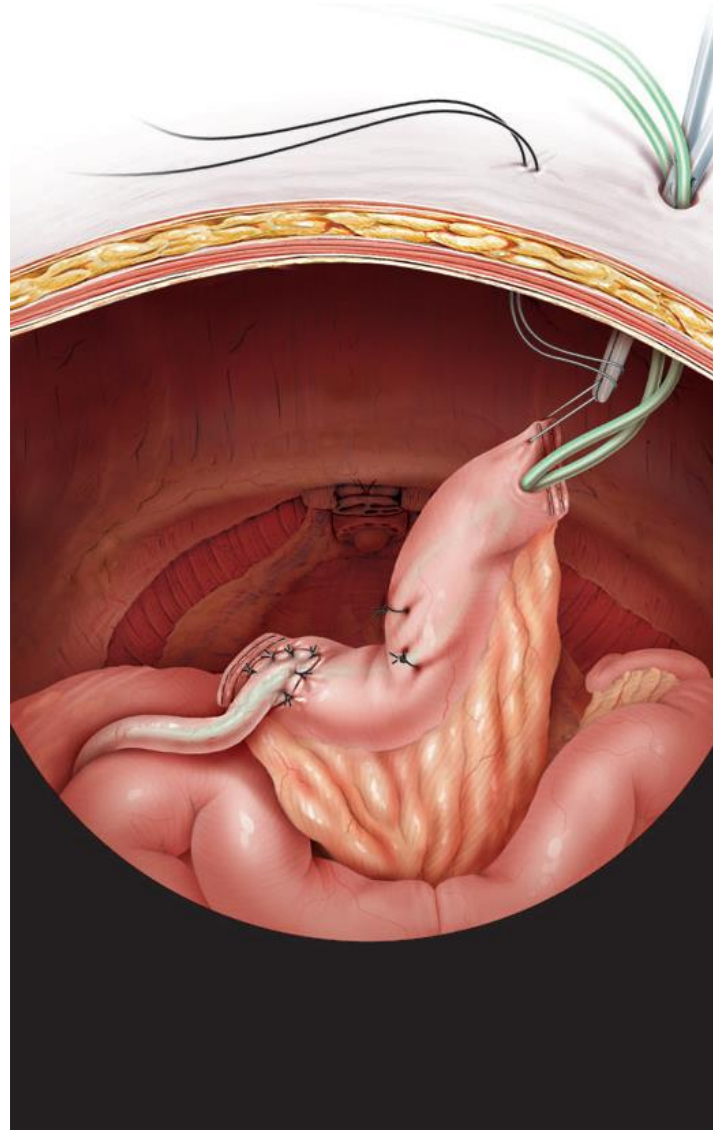


Step 4

Mark optimal stoma sites on the rectus abdominis, that are in patient's line of sight, while avoiding creases and skin folds.



Stomia dopo tecnica «robotica»





The epidemiology of obesity [☆]

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^b Department of Physiology, Yong Loo Lin School of Medicine, National University of Singapore (NUS), Singapore

^c Department of Nutrition, Exercise and Sports - Obesity Research, University of Copenhagen, Denmark

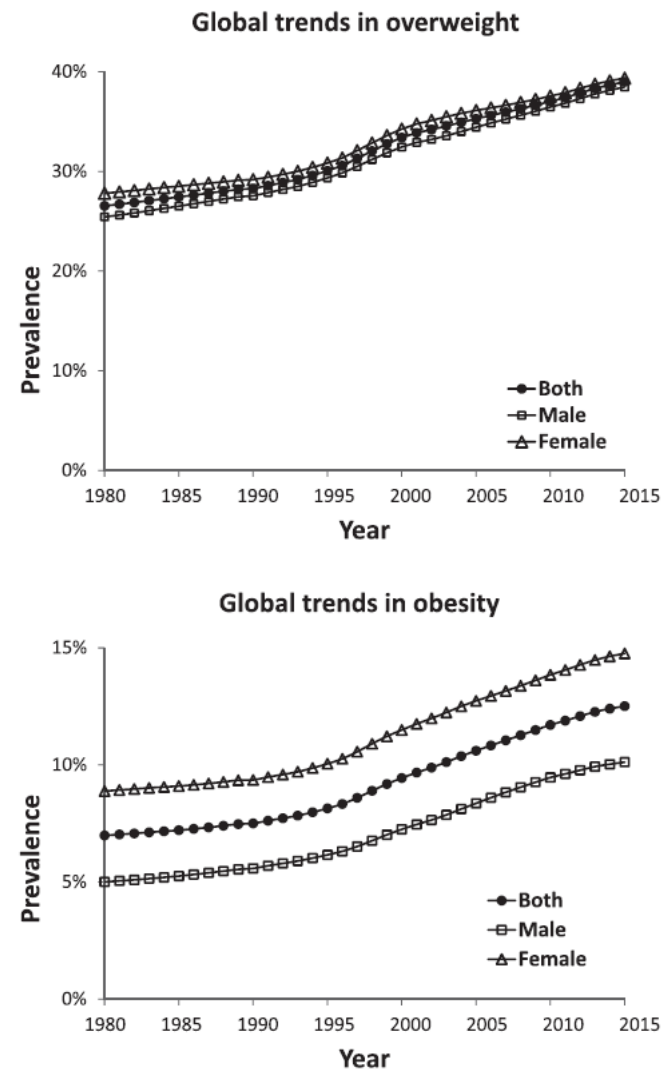


Fig. 2. Age-standardised global prevalence of overweight (top) and obesity (bottom) in men and women > 20 years old by year (ca. 1980–2015).

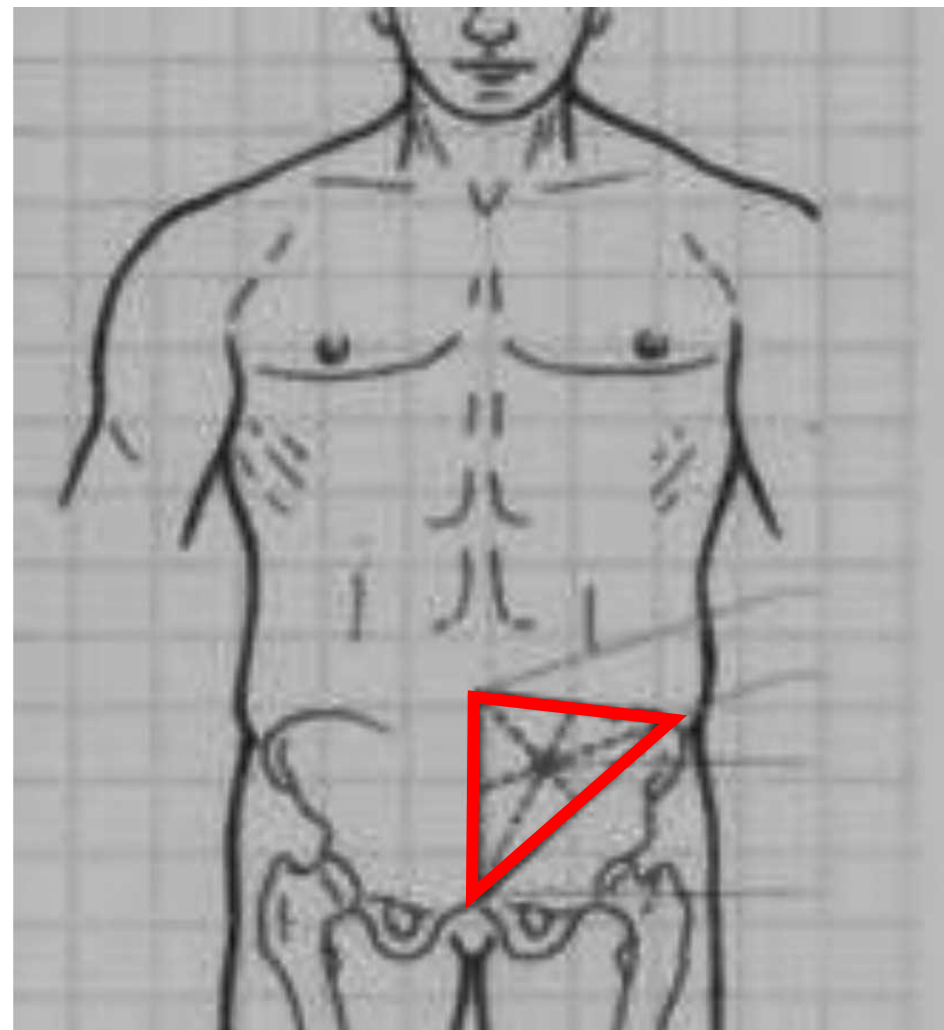


Italian Society of Surgery and Association of Stoma Care Nurses Joint Position Statement on Preoperative Stoma Siting

Gabriele Roveron ■ Giorgio De Toma ■ Maria Barbierato

Preoperative Stoma Siting

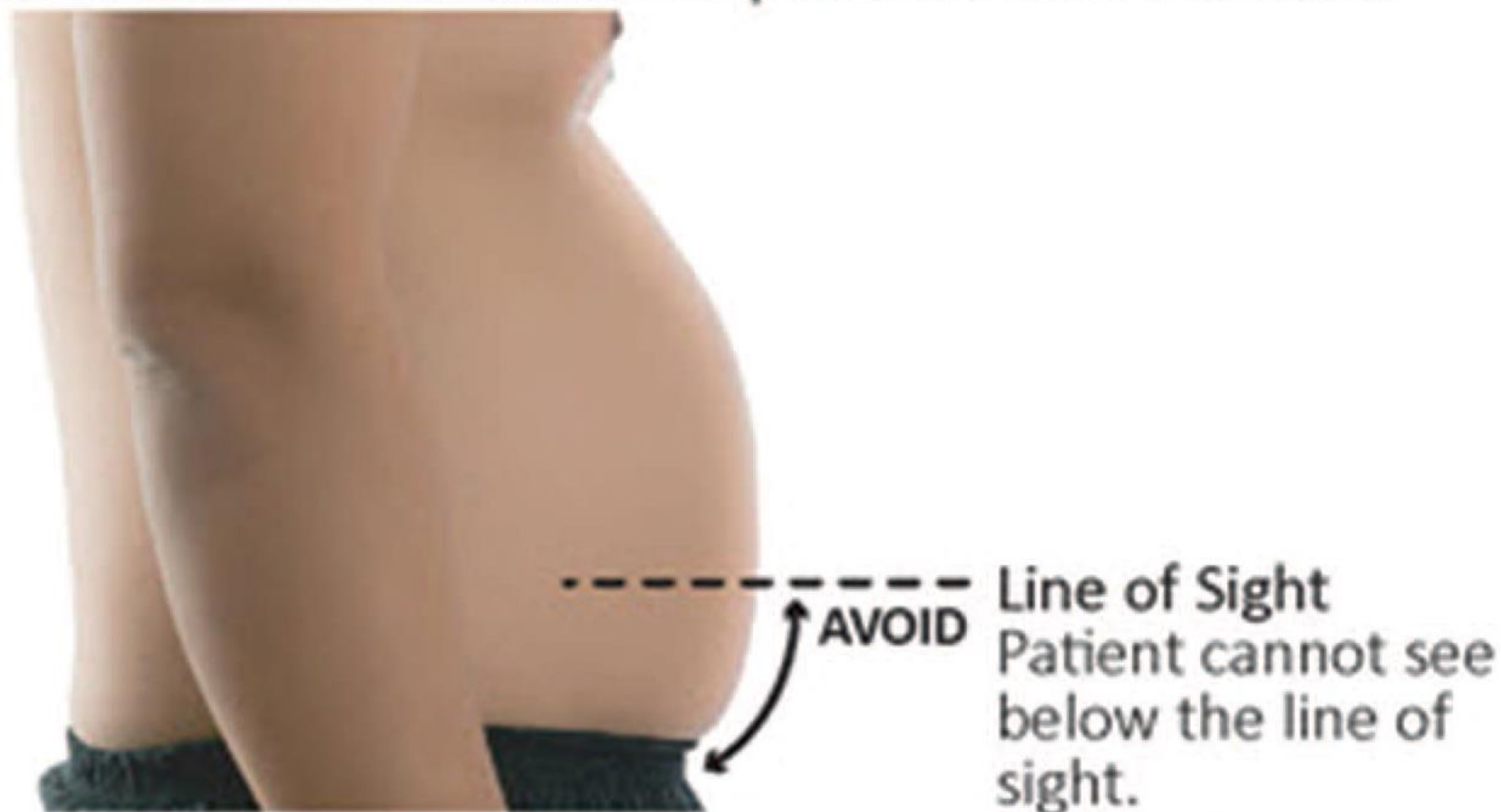
Preoperative siting is vital to the rehabilitation process of stoma patients. Associated counseling provides the opportunity to establish a relationship of trust with patients and their family and to (1) assess their knowledge about the reasons for surgery and stoma construction; (2) assess the patient's physical characteristics and psychological needs (which may affect the choice of stoma location); and (3) start an educational process aimed at providing autonomy in the management of the stoma.⁴ After observing and assessing the shape of the abdomen and how it changes as posture changes, it is necessary to find a skin area that is reasonably large and flat (ie, with no scars, wounds, or skin folds) and away from anatomical structures such as bone saliences, navel and *linea alba*, which enables (1) the application of an appliance for the functional collection of effluents and the prevention of sudden and repeated detachments of the pouching device that could impair skin integrity and, above all, the patient's social life and self-esteem; (2) prevention of stoma complications such as peristomal hernia, retraction, prolapse, and peristomal skin lesions; and (3) rapid recovery of patient autonomy and self-esteem.



Ostomy Triangle

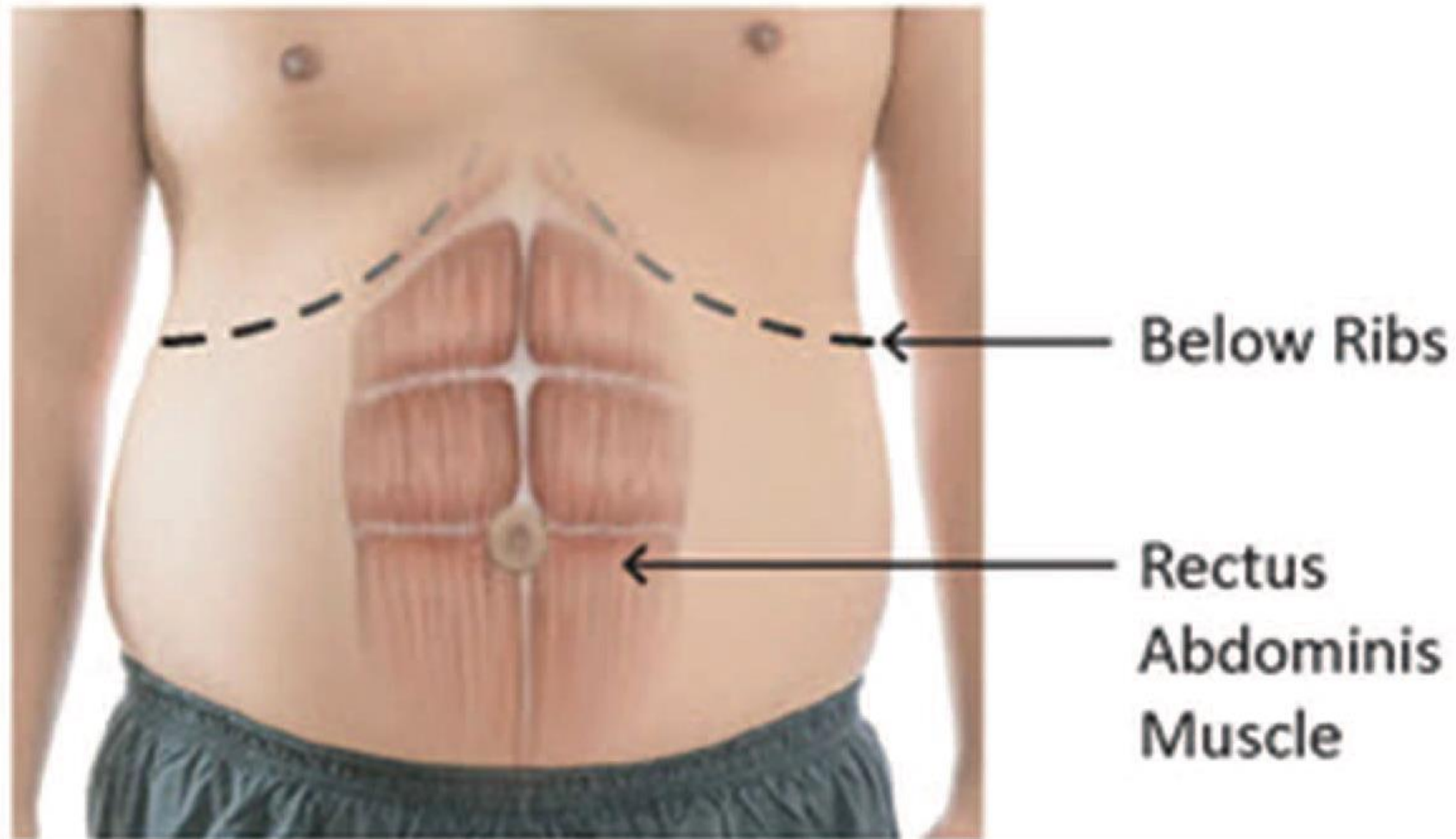
Step 1

Look at the profile of the patient. Notice where the abdomen curves back under toward the body. The underside of the abdomen is not visible to the patient. Avoid this area.



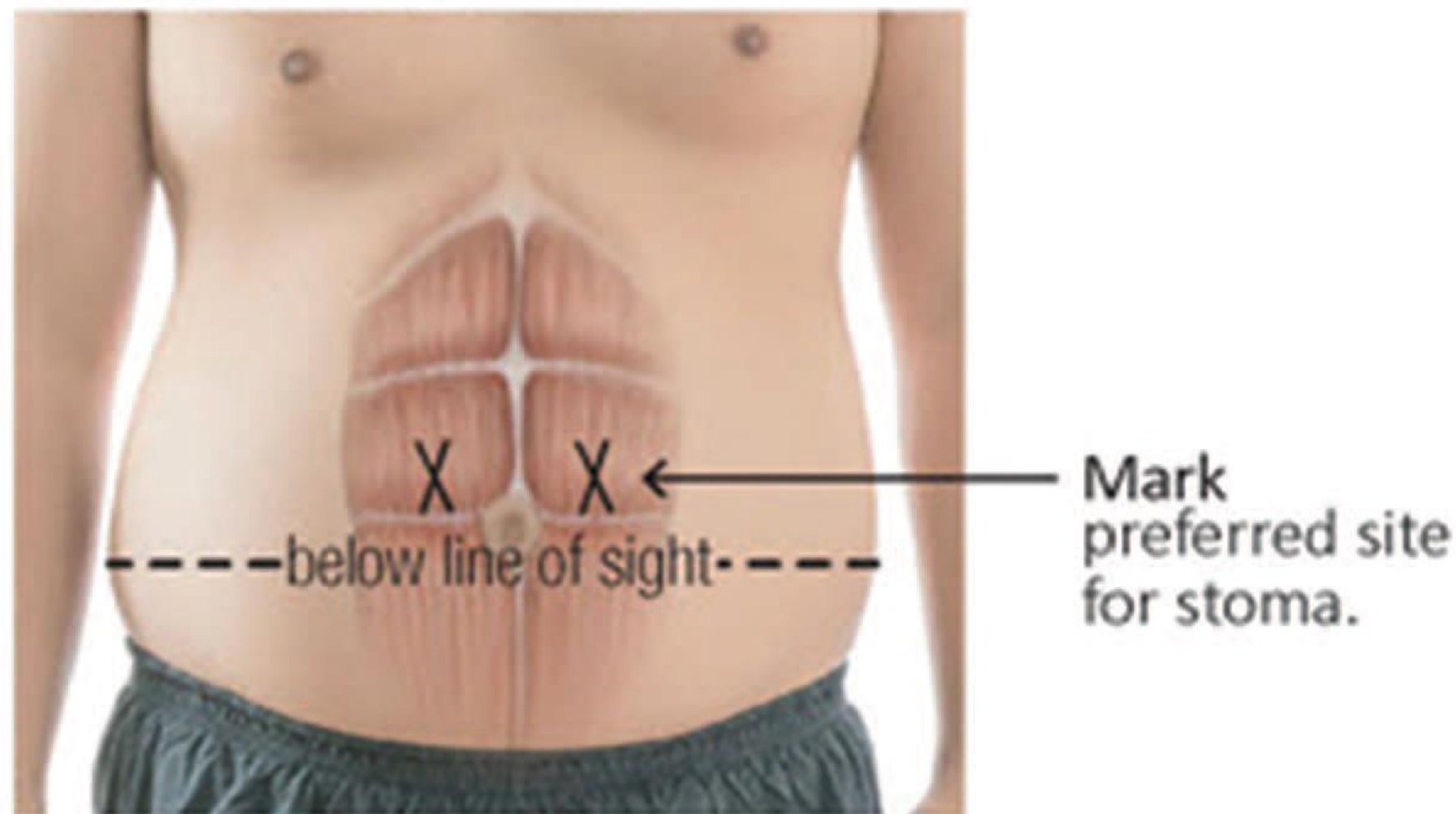
Step 2

Identify and target the rectus abdominis muscle below the ribs.



Step 3

Mark optimal stoma sites on the rectus abdominis muscle, that are in patient's line of sight, while avoiding creases and skin folds.



Peristomal body profile assessment tool

Define your patient's peristomal body profile to identify an appropriate ostomy solution

Patient name

Date

Nurse name

1	The form of the area around the stoma The form may change when sitting, lying down or moving.	Regular	The area is more or less level with the abdomen, although the skin surface may be uneven
		Inward	Sinks into the abdomen creating a hollow
		Outward	Rises from the abdomen creating a peak

Regular



Inward



Outward



2

Selected form being uniform or variable

Uniform

The form is consistent across the stoma area

Variable

The form is not consistent across the stoma area

Regular
Uniform



Inward
Uniform



Outward
Uniform



Variable



Variable



Variable



3

Soft or firm abdomen

Soft

The area yields to pressure (like when pressing a water mattress)

Firm

The area resists pressure (like when pressing under your heel)

Soft abdomen



Firm abdomen



4

Superficial creases or deep folds

Superficial

The skin is lined, furrowed or wrinkled

Deep folds

The area has deep folds of loose skin or excess fat

Superficial creases

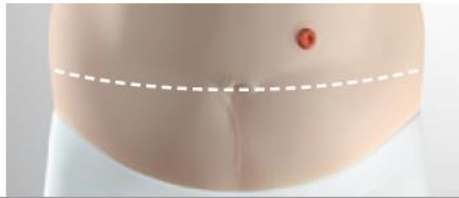


Deep folds



5	Location of stoma	Above bending line	The stoma is located near the ribs
		At bending line	The stoma is located where abdomen folds
		Under bending line	The stoma is located below the bending line

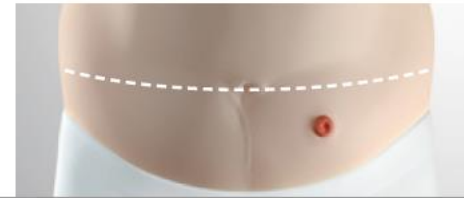
Above bending line



At bending line



Below bending line



6	Position of the stoma opening	Above skin surface	The stoma rises over the skin surface
		Level with skin surface	The stoma is level with the skin
		Below skin surface	The stoma is retracted from the skin

Stoma opening above Skin surface



Stoma opening level with Skin surface



Stoma opening below skin surface



Complicanze stomie urinarie



Complicanze stomie urinarie



Complicanze stomie urinarie





WOCN Society and AUA Position Statement on Preoperative Stoma Site Marking for Patients Undergoing Urostomy Surgery

Ginger Salvadalena ■ Samantha Hendren ■ Linda McKenna ■ Roberta Muldoon ■
Debra Netsch ■ Ian Paquette ■ Joyce Pittman ■ Janet Ramundo ■ Gary Steinberg

Ostomy education and stoma site selection should be performed preoperatively for all patients when an ostomy is a possibility.¹ Multiple studies indicate that patients who have their stoma site marked preoperatively by a trained clinician have fewer ostomy-related complications.²⁻⁷

An appropriate stoma site may decrease ostomy-related complications such as leakage of the pouching system and peristomal dermatitis. It may also influence the predictability of a pouch's wear time, ability of the patient to adapt to the ostomy and become independent, and may even help control healthcare costs. Preoperatively marking the stoma site allows assessment of the patient's abdomen in multiple positions, which promotes selection of the optimal stoma site. In addition, this preoperative session promotes a patient-centered approach respecting the individuality, values, and information needs of the

Conclusioni

L'aspetto cruciale è la scelta «condivisa» della posizione della stomia tra Urologista, Urologo e Paziente nei casi più complessi

Ridiscussione collegiale dei «fallimenti»

Attenzione al profilo corporeo e alle interazioni urine-cute del Paziente

Ringraziamenti

