

Coming Event

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| <p>1. International Ostomy Day
October 12, 2002</p> <p>2. Asian Ostomy Association
Conference in Manila, Phillipines
October 23- 26, 2002</p> <p>3. 18th World Congress of Digestive
Surgery in Hong Kong
December 8 - 11, 2002</p> | <p>4. Half-Day Wound Care Seminar 2002 in
HAHO, Hong Kong
(Sponsor by Paul Hartmann Ltd.)
December 16, 2002</p> <p>5. 1st Asian Pacific Enterostomal Therapy
Nurse Association (APETNA)
Conference in Bangkok, Thailand
October 25 & 26, 2003</p> |
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Announcement

HKETA Executive Members for the year 2002 - 2004

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Refeeding of Chymus into a High-output Jejunostomy

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Background of the Client

Mr. Law was a sixty-two years old retired captain of a tow ship from Macau for about ten years. He had partial gastrectomy performed for carcinoma of stomach in a Hong Kong hospital seven years ago. After retirement, Mr. Law bought a flat in Macau and the whole family moved there. In May 1998, he presented himself to a Macau hospital complaining of severe abdominal pain with vomiting. He was diagnosed as having intestinal obstruction and resection of necrotic small bowel was performed on 19th May 1998. However, the operation was complicated with wound infection and bile leakage from the drain site on fourth post-operative day. On 29th May 1998, he was referred to a hospital in Hong Kong for further management. An emergency operation - wide debridement, enterolysis of strangulated bowel, marlex mesh application to lay open wound, temporary right loop jejunostomy and peritoneal lavage was performed on 30th May 1998. He was cared for in a high dependence unit for two days before transferring back to a colorectal ward for continuous care on 1st June 1998.

Literature Review

The content inside the jejunum is the major organ for nutrient absorption; most of the fats, proteins and vitamins are absorbed in this area. As the absorptive capacity depends on the length and function of the proximal bowel, the problems of fluid and electrolytes imbalance probably will be resulted if any bowel resection is performed. Client, who has formation of enterostomy such as loop jejunostomy placed in the upper part of the gastro-intestinal tract for any surgical reasons, the volume of output in jejunostomy may approach 2400ml per day (Hampton and Bryant, 1992;

Blumberg, 1993). In addition, the absent passage through the lower gastro-intestinal tract results in vitamin, trace element and bile salt deficiency. Therefore the problem of malnutrition will increase the risks of infection and delay the rehabilitation period (Christenson and Gstundtner, 1985; Turk et al, 1986; Chaffer, 1994). The provision of optimal nutritional care, with the promotion of and maintenance of good nutritional status, results in more rapid wound healing, decreased incidences of infection and other complications (Chaffer, 1994, Sweed et al, 1995). Parental nutrition is the appropriate form of nutritional support only when the gastro-intestinal tract is not functioning correctly (Woodruff and Itsiopoulos, 1989; Bryant, 1992; Chaffer, 1994). The output from the proximal loop jejunostomy is considered as chymus and contains adequate fluid, electrolytes and nutrition for the client. Re-feeding of chymus back into a high output jejunostomy not only encounter the metabolic problems due to excessive loss of water and electrolytes imbalance but also restore the nutritional status and rehabilitation as soon as possible.

Assessment of the Client

Physical status

On admission, Mr. Law looked pale and dehydrated though conscious and alert. His visual function, hearing ability, elimination pattern and mobility were in normal patterns. He was an ex-smoker and drinker with no allergic history. Mr. Law had low-grade fever and his blood pressure, pulse and respiratory rate were all within normal range. The abdomen was soft with positive bowel sound. An old partial gastrectomy scar was found at epigastrium. The recent operated incisional wound at left paraumbilical region was infected and gapped. The wound bed tissue was yellowish in colour and draining yellowish pus-like discharge, it measured 12cm (length) x 3 cm (width). A drainage collection bag was applied to the old drain site at right lower quadrant to collect bile leakage.

An emergency operation was arranged to counteract his poor general condition - wide debridement of necrotic tissue, enterolysis of adhesion bowel, marlex mesh application to the lay opened wound after debridement, temporary right loop jejunostomy and peritoneal lavage were performed on 30th May 1998. A broviac catheter was also inserted for total parental nutrient because of prolonged fasting and underweight (body weight = 36kg).

The lay opened wound measured 15cm (length) x 10 cm (width) and an adhesive marlex mesh was applied over it. The wound bed tissue was reddish yellow colour with yellowish discharge. The jejunostomy was oval shape and beefy red colour with no sign of mucocutaneous juncture separation. Peristomal skin was intact with no irritation. However, the temporary right loop jejunostomy had a high output of 2.5 litres per day and the blood test showed hypokalaemia, hyponatraemia and hypoalbuminaemia.

Psychological status

Mr. Law was anxious about his physical illness and he became frustrated at times. He was not willing to talk and share his feelings with others, including medical, nursing, allied health and minor staff. Sometimes he expressed his anger towards anyone whenever there was any delay response from his request. One night he asked me why nurses poured the drainage from the jejunostomy collection bag back into his stoma. He claimed that it was an unpleasant feeling as some clinical nurses considered those drainage from the jejunostomy collection bag as 'faeces'.

Social status

Mr. Law's family lived in Macau and he had few visitors. His daughter visited him more frequently as she worked in a commercial company in Hong Kong. His wife and his son worked in Macau and could only visit him over weekends. Other relatives and ex-colleagues visited him occasionally. There was no financial concern as Mr. Law received pension from his previous employer and he paid his hospital fee as a Hong Kong resident. He did not have any religion

belief.

Functional status

Mr. Law's mental status was normal. His physical mobility was limited to bedside; he needed help during mobilization exercise as there were several drainage tubes from the operation. He was allowed to have fluid diet only and there was small amount of faeces eliminated from the rectum.

Potential or Actual Problems Resulting from the Client's Health Status:

Physical problems

Fluid and electrolytes imbalances were identified as there was an excessive fluid loss of up to 2.5 litres via the temporary right loop jejunostomy per day. Malnutrition related to prolong fasting, excessive nutrition loss via the temporary right loop jejunostomy and inadequate caloric intake from the peripheral line. Meanwhile, there were technical problems in implementing re-feeding in the clinical area. The client also was at potential risk for infection, which was related to his poor nutritional status, lay opened wound and complications of total parental nutrient feeding.

Psychological problems

The unpleasant feeling towards the process of 're-feeding of chymus' was regarded as 're-feeding of faeces' by client was identified. The nurses' knowledge deficit and negative comments toward re-feeding of chymus further exert unnecessary adverse effect on the client's acceptance.

Social Problems

Inadequate psychological support by significant others was identified.

Strategy Used to Improve Quality Nursing Care as a Stomal Nurse Specialist

1. *To promote the psychological comfort and support by implementing effective communication between the client and the Stomal Nurse Specialist*

Holistic health approach for improving quality nursing care becomes a new direction in the current health care services. Being a nursing profession, it is necessary to maintain an effective communication channel with the clients so as to alleviate clients' fear and anxiety. The provision of fragmented physical care may not satisfy the needs of any clients in terms of physical, psychological, social and spiritual elements. The effective form of communication includes verbal and non-verbal approaches.

Stomal Nurse Specialist gives appropriate and clear explanation about the aim and objectives of re-feeding procedure in order to alleviate Mr. Law's worry and misunderstanding. It is necessary to allow him to express his feelings. Supportive attitude of nurses will enhance the psychological comfort in clients. Both the Stomal Nurse Specialist and other clinical nurses have to be aware of their own non-verbal cues in communicating with clients. Misunderstanding sometimes arises by those inappropriate eye contact, facial expression and gesture.

2. *To convince the Ward Manager for resource and managerial support by implementing effective communication between the Ward Manager and Stomal Nurse Specialist*

As re-feeding procedure is newly introduced in this clinical area, it is not surprised that clinical nurses will question its effect. Stomal Nurse Specialist has to influence the clinical nurses for their acceptance and cooperation on the procedure. Ward Manager is the leader of the clinical ward. Without the resources and managerial support from the Ward Manager, the re-feeding procedure probably cannot be preceded. Initially, the Stomal Nurse Specialist needs to formally approach the Ward Manager to discuss and agree on the appropriate time for re-feeding procedure such as weekday afternoon. Literature information about the re-feeding procedure; its phenomenon and effectiveness against other alternatives; technical details and required equipment as well as resource implications were prepared ready for reference and discussion. Furthermore, educational program on re-feeding procedure for the nurses was planned aiming

to facilitate knowledge and acceptance by nurses and Ward Manager.

3. *To initiate the educational program on re-feeding to clinical nurses: enhancing their knowledge about re-feeding, clarifying the myth and changing attitude towards re-feeding*

Re-feeding is not a common nursing procedure in Hong Kong. Teaching aims to help learners enrich their knowledge by linking new with existing material, challenging prevailing ideas, and forming bridges between theoretical and practical information (French, Neville and Laing, 1994). Stomal Nurse Specialist has the responsibility to initiate education program for clinical nurses so as to update their nursing knowledge, gain their acceptance and co-operation for this procedure. Six identical seminars (three hours each) were arranged and there were slides show and lecture notes. Demonstration and return demonstration on how to perform re-feeding and its related nursing care using a jejunostomy model were also included. Nurses were encouraged to ask questions in order to clarify any misunderstanding. Scheduled bedside clinical demonstration was also arranged.

4. *To tackle the technical problems of re-feeding procedure*

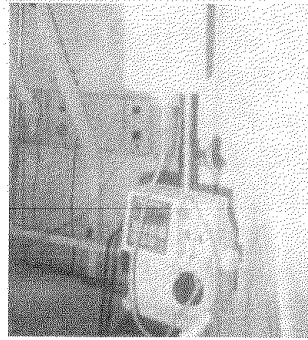
As the nature of chymus from the proximal loop jejunostomy is semi-solid with residue, it is difficult to re-feed the chymus via a silicon coated Foley catheter into the distal loop jejunostomy directly. The problem of blockage will be expected. Enlarging the existing drainage keyholes of the silicon coated Foley catheter is needed to facilitate the re-feeding procedure. Furthermore, the use of a blender to make the chymus into a more fluid nature prior to re-feeding is necessary. As there was no blender in the clinical area, the Stomal Nurse Specialist had to discuss with Mr. Law's relative to buy a new blender for the procedure.

Use of feeding pump (picture 1) during the re-feeding procedure is strongly indicated to ensure accurate infusion amount, adequate fluid and nutritional inputs (Blumberg, 1993). The adjustable and steady infusion rate guarantee that no excessive pouring

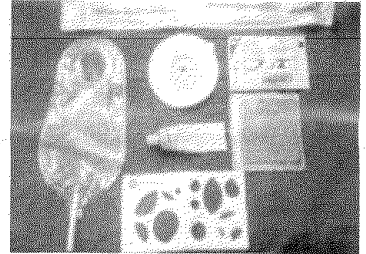
force will be exerted on the bowel lumen that may lead to any accidental damage. The problems of early blockage and malposition of the silicon coated Foley catheter can be detected by the preset alarm system. To minimize the risk of cross-infection, the blender was labelled for the client's only. The container of the chymus for re-feeding and blender were cleaned daily with detergent. The infusion tubing was also discarded daily. The silicon coated Foley catheter, two-piece drainage system and collection bag were changed three times per week.

In order to ensure safety and effective intubation of the silicone coated Foley catheter into the distal loop jejunostomy, Stoma Nurse Specialist would accurately measure the diameter of the jejunostomy using a measuring guide. Probing the channel of the jejunostomy gently with the last finger would enable to determine the anatomical condition of the stoma such as any stricture or stenosis etc. All the required equipment are available such as Silicone-coated Foley catheter (Wembley Rubber Products, Malaysia); ConvaTec Stomahesive paste; Hollister measuring guide; Coloplast two-piece urostomy bag UR02002; 3M Tegaderm Transparent Dressing; ConvaTec DuoDERM (picture 2).

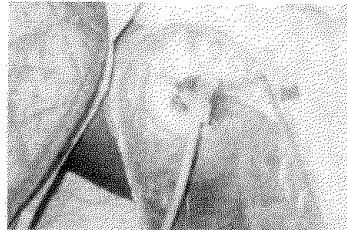
A 2-piece skin barrier wafer with flange was placed around the jejunostomy, the silicon coated Foley catheter was inserted into the 2-piece urostomy pouch and then further intubated into the designated jejunostomy (Blumberg, 1993). The depth of the intubation was estimated at 5cm and a marking was made on the silicon coated Foley catheter. In order to prevent any leakage from the weak point of the re-feeding system, extra skin barrier paste was added to the opening where the Foley catheter came through the plastic of the urostomy pouch. A piece of DuoDERM can be adhered over the location for urostomy pouch with flange before making an open window. Furthermore, two pieces of transparent film dressing were used to sandwich the Foley catheter Fr 14 and the catheter was secured in a perpendicular position to the jejunostomy (picture 3 and 4). All the drainage was collected into a bedside bag (picture 5)



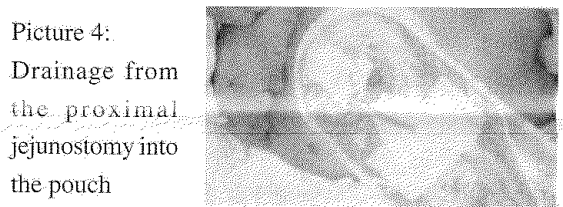
Picture 1:
Kangaroo feeding pump



Picture 2:
Equipment for the procedure



Picture 3:
Open window after insertion of Foley catheter



Picture 4:
Drainage from the proximal jejunostomy into the pouch



Picture 5:
Drainage from the proximal jejunostomy into the bedside bag

Evaluation of the Outcomes of the Therapeutic Interventions

Effective communication between client and nurses is very important. Mr. Law showed acceptance and reduced psychological discomfort toward re-feeding procedure since the interventions. He had also gained 1 kg body weight (from 36kg to 37kg) after the implementation of the re-feeding procedure, though it might be the effect of both re-feeding procedure and the total parental nutrient he was receiving continuously.

Mr. Law had two episodes of fever with chills and rigor, re-feeding was suspended at the time to rule out all the suspicious causes. A specimen of the chymus was collected and sent for culture and sensitivity test. The result did not show any suspicious pathogen. The possibility of infection from the lay opened wound and the complications of total parental nutrient were not excluded.

Conclusion

Re-feeding of chymus is to restore the fluid and electrolyte balance and to correct the nutritional status of a client when there is a high output from an enterostomy. It is an uncommon nursing procedure and different kinds of problems have to be addressed - the client's and nurses' negative perception towards re-feeding, inadequate knowledge and technical problems of the procedure and inadequate communication. The Stomal Nurse Specialist plays an important role in facilitating new knowledge and implementing new procedure in the clinical area. He/she uses various strategies to encounter problems such as promoting effective communication between client and health care professionals, enhancing nurses knowledge and acceptance of new procedure and being innovative to tackle and solve technical problems.

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"We've done it" - 16th Biennial Congress of WCET"

A group of 20 HKETA members left Hong Kong on 5 July 2002 to attend the 14th Biennial Congress of the World Council of Enterostomal Therapists (WCET) in Florence, Italy. All members had mixed feelings in attending this biennial international congress. Apart from being excited to meet old friends again, they faced the challenge of winning the right to host the 16th Biennial Congress of the WCET in Hong Kong 2006.

On arrival at Florence on 6 July 2002 and after checking in at a hotel, members put on their specially made cream-coloured jacket and headed to the bidding venue. As a team, we all went into the presentation room and Mr. Pang Chak Hau presented our proposal to the WCET Board Members and industrial representatives. Our opponents were Malaysia and Thailand, who were both able to offer a financially more competitive proposal. In the next few days, we anticipated anxiously for the announcement of the final result on 11 July 2002.

With great honour, I am pleased to announce that we, the HKETA, have been awarded the privilege of hosting the Congress in 2006. May I take this opportunity to thank you once again for your continuous support. We would not have been able to make this dream come true without you. I am sure we can continue to rely on you as our partners to make the 16th Biennial Congress of the WCET a tremendous success.

Susan Law