The ileostomy & internal pouch
Support Group
Registered Charity

Temporary Loop Ileostomies
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During the 2003 National Council in London Professor Norman Williams gave a talk on Loop Ileostomies and Complications of Stomas. This is a summary of the first part of his talk.

Background

Most current members of **IA** will have had what is known as a total proctocolectomy for ulcerative colitis or Crohns disease. This involves the complete removal of the colon, rectum and most of the anal canal, together with the anal sphincters. The remaining anal canal is then sewn up and the last portion of the small bowel, the ileum, is brought to the surface of the abdominal wall as an end or permanent ileostomy. The faecal contents empty into an appliance, or ostomy pouch, that is attached to the outside of the body.

However in recent years many more people in such circumstances will have had the colon and rectum removed but the anal canal and sphincters left intact. A new rectum is fashioned from the ileum and is then sutured to the anal canal to form what is usually known as an ileoanal pouch. This is now the most common procedure performed for the surgical treatment of ulcerative colitis. With the advent of new techniques and equipment, including an instrument called the 'stapling gun', which enables the intestine to be joined up safely at a much lower level of the bowel than was possible before, the most favoured form of pouch is the J-pouch. This is made by freeing two loops of ileum side by side, opening the walls of the loops, and stitching them together to form a large pouch which is then joined to the anal canal with the stapling gun.

In order to allow the anastomisis to heal properly without the risk of infection from the faecal contents, or some concern that the join might not be strong enough at first to prevent any leaks occurring, a temporary defunctioning loop ileostomy is often created as part of the procedure. For this, a portion of the ileum is brought out as a loop ileostomy, with a small opening in its side to allow the faecal effluent to exit through there and so protect the join. After two to three months, a detailed X-ray is taken to make sure that the bowel is fully healed. The opening in the loop ileostomy is then closed, and the ileum replaced back into the abdominal cavity, allowing the faeces to flow normally through the anal canal.

In cases of cancer of the colon and rectum, the surgeon removes the portion of the bowel containing the cancer, together with a healthy margin of tissue either side of the cancer, and the surrounding lymph nodes. Depending on the exact position of the cancer within the bowel, the two ends of the remaining bowel can usually be joined together and normal bowel function is restored.

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In some cases, particularly if the cancer is in the rectum or lower colon, this may not be possible, and the colon has to be brought to the abdominal surface as an end colostomy. However, as mentioned above, with the new stapling gun about 75% of people with cancers of the large bowel can now have 'sphincter saving' operations with the joining of the remaining bowel to the anal canal with the sphincters intact. As in the ileo-anal pouch operations for ulcerative colitis, most operations for colorectal cancer where the bowel ends are joined together, will be given a temporary colostomy or ileostomy for two to three months to enable the join to heal.

Several studies have compared temporary loop ileostomies with the more usual temporary colostomies, and these studies have shown that the patients find the ileostomies easier to live with, complication rates were lower with the loop ileostomies, and they were also easier to reverse than colostomies. It is now suggested that the loop ileostomy is the best procedure for the defunctioning of a colorectal anastomis for cancer. With the increase in colorectal cancers due to the aging of the population it is likely that there will continue to be a steady increase in the number of temporary ileostomies that are formed over the next few years.

Temporary ileostomies are also used for other bowel conditions, where the bowel needs to have time to heal, like severe intestinal fistulae, diverticulitis and other functional bowel conditions, and also for special operations for rectal sphincters.

Why should IA members be interested in people with temporary ileostomies?

Most people with colorectal cancers have sphincter saving operations with loop ileostomies rather than the colostomies they used to have. Although most of them will have their ileostomies reversed, as do those with a temporary ileostomy after a pouch operation, a significant proportion will not be well enough to have it closed, and some people may later have to come back to an ileostomy.

In addition, although most people with a temporary ileostomy should have it reversed within three to four months, with the current pressure on hospital beds, many are having to wait for months or even one or two years. These people often need some help and advice on problems of daily living which can only be given by someone with personal experience of living with an ileostomy. Therefore it is felt that **IA** should be available for people with temporary ileostomies.

Discussions will take place over the next few months as to how our members could best offer some help and advice within the tenets of the organisation.

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