Clinical Practice Guidelines: Ostomy (1/3)

- Patients undergoing elective stoma creation should receive pre and postop education by a specialized provider, 1B
- Appropriate potential ostomy sites should be marked preop by a trained provider, when possible, 1B
- When feasible, laparoscopic ostomy formation is preferred to laparotomy, 1C
- When possible, both ileostomies (2cm) and colostomies (1cm) should protrude above the skin surface, 1C
- In nonobese patients, the routine use of a support rod is not necessary for loop ileostomy construction, 1A
- A loop ileostomy or colostomy is effective for fecal diversion, 1B

Davis BR et al. *Dis Colon Rectum* 2022;65(10):1173-90
Clinical Practice Guidelines: Ostomy (2/3)

The routine use of prophylactic mesh to prevent parastomal hernia is not recommended, 2A. Extraperitoneal tunneling of an end colostomy may decrease the risk of parastomal hernia, 2B.

Routine contrast studies w/ $h_2O$-soluble contrast (in the absence of a clinical suspicion of anastomotic dehiscence or stricture) may not be necessary before closure of a protective ostomy, 2C (DRE, endoscopy, clinical course and suspicion may be used).

Early ileostomy closure (at 1-6 weeks) may be performed in select low-risk patients with a colorectal anastomosis without clinical evidence of anastomotic leak, 2B.

Loop ileostomy closure can be performed using stapled or handsewn techniques, 1A.

Skin-site approximation should be performed when feasible (e.g. purse-string), 1A.

Managing a new ileostomy with a perioperative clinical care pathway may decrease risk of readmission, 2B.

Davis BR et al. Dis Colon Rectum 2022;65(10):1173-90
Minimally Invasive Hartmann reversal is a safe alternative to open, 1B

Parastomal hernia repair should typically utilize mesh reinforcement, 1C

Minimally Invasive parastomal hernia repair may be performed in selected patients, 1C

Davis BR et al. Dis Colon Rectum 2022;65(10):1173-90