

A Rare Stoma-Related Complication: Parastomal Evisceration

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Abstract Defunctioning stoma is a commonly used colorectal surgical procedures. The stomal complications recorded are usually classified as early and late complications. Parastomal hernia is a common complication of stomal surgery. We present a very rare stoma-related complication developed after parastomal hernia and described parastomal evisceration.

Keywords Colostomy · Complication · Parastomal hernia · Evisceration

Case Report

Colorectal surgery is associated with a high rate of stoma formation. Stoma formation can be temporary or permanent. Temporary stomal complications are low, due to most of the patients undergo early stoma reversal. The rate of permanent stomal complications is high, and may increase even more over time [1–3]. Our aim is to present a very rare stomal complication described parastomal evisceration requiring urgent intervention.

A 62-year-old man was admitted to the emergency department with abdominal distention, nausea, vomiting, and

swelling around the colostomy. He underwent Miles' operation for a rectal carcinoma 1 year ago. Parastomal hernia occurred 8 months after the surgery. He had a history of chronic obstructive pulmonary disease for a long time. Physical examination revealed mild abdominal distention, tenderness in all abdominal quadrants, and end colostomy with irreducible parastomal hernia in the left lower quadrant. Upright abdominal X-ray revealed multiple air-fluid levels (Fig. 1). During the observation the patient developed prolapse and small bowel evisceration, followed by retching and coughing. Eviscerated small bowel loops were dilated and slightly edematous (Fig. 2). Gentle manual reduction could not be performed. To prevent ischemic damage of the small bowel loops, stomal opening was expanded with small incision and the patient underwent emergency surgery. Because of the large fascial defect and contaminated wound, colostomy was opened to the opposite side and fascial defect was closed. The postoperative course was uneventful and the patient was discharged on postoperative day 4.

Stoma formation is a usually performed procedure in colorectal surgery. The most commonly performed stomas are ileostomy and colostomy [1, 2]. The stomal complications recorded are usually classified as early and late complications. Early complications include inappropriate location, stoma retraction, skin excoriation, leakage, dehydration, and stoma necrosis. The late complications include parastomal hernia, stomal prolapse, stenosis, and peristomal dermatitis [2, 4, 5]. Several studies reported overall complication rates following stoma formation from 21 % to 70 % [1–3]. A parastomal hernia is defined as an incisional hernia

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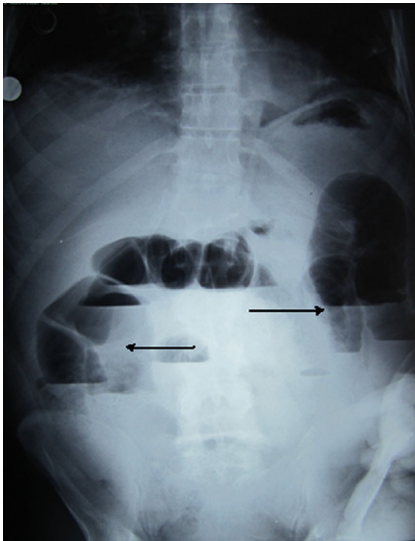


Fig. 1 Upright plain abdominal X-ray revealed multiple air-fluid levels (*arrows*)

associated with an abdominal wall stoma. The reported incidence of parastomal hernia for end colostomy and loop colostomy ranges from 4 % to 48 % and 0 % to 30.8 %, respectively [6].

Parastomal evisceration is a very rare complication. Only one case has been reported in the literature so far. In the case presented by Park et al. [7], the prolapsed ileostomy had ruptured during the manipulation, and the small bowel had become eviscerated through the resulting defect. In our case, parastomal evisceration was spontaneously developed at the edge of end colostomy. The main reasons of evisceration were increasing intra-abdominal pressure and cough. Such a stoma complication have not been reported until today.

Parastomal evisceration is a very rare stoma complication and requires urgent surgical intervention. To prevent ischemic

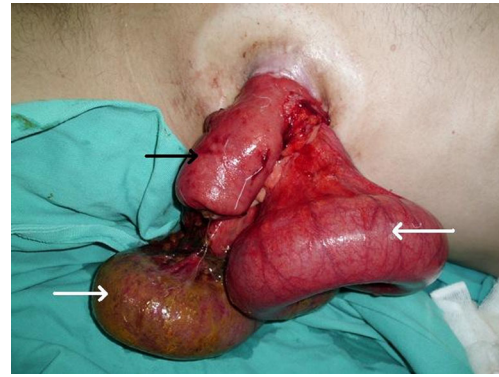


Fig. 2 Prolapsed colon (*black arrow*) and eviscerated loops of small bowel with contaminated feces (*white arrows*)

damage, a small incision should be performed on the edge of the stomal opening.

Conflict of interest No conflicts of interest.

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