

Peristomal skin care: an overview of available products

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Abstract

Intact skin provides a protective barrier between the body and its environment. The frequent application and removal of stoma appliances can damage skin by stripping away the epidermal layer. Hydrocolloid flanges in either a one- or two-piece appliance hold moisture in the mass and are therefore more skin friendly than older appliances with acrylic adhesives, making hydrocolloid the choice for ostomy appliance manufacturers. Peristomal skin problems are a significant problem for the stoma patient. As many as one-third of colostomy patients and more than two-thirds of ileostomy and urostomy patients will be affected (Lyons and Smith, 2003). The correct and judicious use of barrier creams, gels, lotions, sprays and wipes in peristomal skin care can play an important role in giving the stoma patient a good quality of life.

Key words: Adhesive ■ Epidermis ■ Hydrocolloid ■ Peristomal ■ Solvent

The skin is an important organ that protects and covers the body. Its main functions are to control fluid loss, regulate body temperature and protect against noxious substances (Sibbald et al, 2003). The superficial layer of the skin, the stratum corneum, makes a protective barrier and consists of keratin-filled corneocytes in a matrix of highly ordered multilamellar lipid sheets that have an appearance of a brick wall. However, if the stratum corneum breaks down the barrier function of the skin becomes impaired (Caliano, 2000; Clay, 2000; Hoggarth et al, 2005). Impairment of the barrier function of the skin can occur with irritants such as urine and faecal matter, moisture, abrasion and biological influences, giving rise to a dry, compromised skin.

Aged skin is particularly at risk and any other co-morbidities the patient may have can cause deterioration in the skin. Skin

aging and changes are often due to intrinsic aging as opposed to photo damage (ultra violet exposure) or lifestyle (Fore, 2006). Recognizing aged skin and the correction of co-morbidities is important in older stoma patients and any adverse effects of nutrition and medication should be rectified. When caring for the older stoma patient, an understanding of what may precipitate damage to the peristomal skin will help with their care. The inappropriate use of adhesives and other agents for the removal of the appliance in patient groups such as the aged (with thinning skin) and neonates (who have thin skin) may well cause damage to the peristomal skin and delay healing (Black, 2000; Sibbald et al, 2003; Rolstad and Erwin-Toth, 2004; Berry et al, 2007). All ostomates are at risk from peristomal skin damage due to appliance malfunction, with up to 19% of ileostomates suffering from this problem (Borwell, 1996).

Adhesive application

The mechanism of adhesive bondage to skin is a physical action. And because the skin has a complex surface structure that is convoluted and contoured, it presents as a mosaic pattern, with an ideal surface for 'keying in' adhesives

(Berry et al, 2007). The effectiveness of adhesive application of the stoma appliance depends on a number of factors:

- The make-up of the adhesive formulation by the appliance manufacturer
- The risk of irritation from the adhesive
- Allergic reaction to the materials on the flange
- Inclusions in the adhesive that may cause contact dermatitis
- Restriction of transpiration of moisture by the adhesive flange.

The development and use of hydrocolloid adhesives in stoma appliance flanges over the last 20 years compared with the previous adhesives of zinc oxide and acrylics, allows active absorption of moisture. This minimizes maceration of the peristomal skin and the moisture is held in the adhesive mass rather than being retained in the peristomal skin (Berry et al, 2007).

Protection of the peristomal skin from the effects of exposure to faecal output, urine and skin stripping from adhesives is extremely important (Borwell, 1996; Porrett and McGrath, 2005). Previously the use of organic polymers and methacrylate, which have occlusive and water repellent characteristics, were used to deliver a protective film to the peristomal skin prior to application of the pouch. The way that these materials were delivered to the peristomal skin were with an alcohol or organic solvent base, which are irritants to peristomal skin. When applied to peristomal skin they can only be removed by using similar skin irritant removers (Wilkinson and Moore, 1982).

The production of skin barriers using silicone polymers, such as dimethicone, as a film forming agent, has revolutionized peristomal skin care. This product has been formulated into aqueous-based creams and lotions to apply before pouch application. A study by Grove et al (1993) showed that areas of denuded stratum corneum had better barrier properties if the skin had been treated with silicone based polymers compared with other barrier treatments. Importantly, the pain on application from silicone-based

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barrier creams is negligible compared with the severe pain on application of alcohol-based peristomal skin products (Grove et al, 1993; Berry et al, 2007).

The use of products containing benzyl alcohol, especially for neonates in incubators, should be avoided. In 1982 it was discovered that there was a link between products containing benzyl alcohol and cardio-vascular collapse of neonates in incubators, subsequently named as 'the gasping baby syndrome'. Consequently, the Food and Drugs Agency and the American Academy of Paediatrics recommended that benzyl alcohol-containing products should be avoided in infant usage (Lesney, 2001; Cutting, 2006).

The value of silicone

Silicone was identified in 1824 by Jöns Jacob Berzelius of Sweden. Silicon makes up 25.7% of the earth's crust by weight and is the second most abundant element after oxygen (Corrosionsource, 2000). Silicone is widely used in cosmetic production and in healthcare, where, due to its skin-friendliness, it can be used in gels, liquids, sprays, emulsions and wipes as skin protectants. Silicone is inert, does not sting and dries without leaving a residue (Cutting, 2006).

In a study by Issberner and Schuren (2004), five silicone-based products using no-sting formulation were examined. Four years before the study, silicone-based skin protectants had been introduced to the market place with little data to support their use. The products included in the study were: Cavilon™ No Sting Barrier Film (3M Health Care Bracknell), LBF® No Sting Skin Barrier (Clinimed), SkinSafe Non-Sting Protective Film (AlphaMed, now Opus Healthcare, Colchester), Skin-Prep™ (Smith & Nephew, Hull, UK) and Comfeel Protective Film (Coloplast Ltd, Peterborough, UK).

A dye retention study was the method used to evaluate the effectiveness of the five paint-on barrier films. Healthy subjects were enrolled and red water-soluble dye was applied to their backs and then was randomly covered in the barrier films. One stain was left uncovered and used as a non-protected control. Subjects were asked to shower daily and return on each of the following five working days for stain intensity measurements. Basic values were done on visit 1 (day 0) and on visits 2–6 values were compared with visit 1. Dye retention on stains covered with Cavilon™ No Sting Barrier Film (3M Health Care,

Bracknell) was significantly higher than for all other products except Comfeel Protective Film (Coloplast Ltd, Peterborough) at day 1, and was significantly higher than for all other products from day 2 onwards. On day 7 there was still considerable dye retention for Cavilon™ No Sting Barrier Film (>30%); however, the remaining four products exhibited dye retention of under 10%. From this study the conclusion was that protectant film barriers provide a long lasting physical barrier that protects the skin, especially peristomal skin, from irritants such as stomal effluent and urine. Lasting for 2–7 days, Cavilon™ No Sting Barrier Film proved to be effective as a peristomal spray or wipe (Issberner and Schuren, 2004).

In a US study by Hoggarth et al (2005) the efficacy of six skin protectants was tested against a known skin irritant (sodium lauryl sulphate). Each phase of the study involved the participation of a minimum of 15 healthy individuals. The products were Aloe Vesta® Protective Ointment (ConvaTec), ProShield® Plus (Healthpoint, Fort Worth, Texas), Triple Care™ Protective Cream (Smith & Nephew, Largo, FL), Baza Cleanse & Protect® (Coloplast, Marietta, GA), Calmoseptine® (Calmoseptine, Inc, Huntington Beach, CA), Cavilon™ One-Step Skin Care lotion (3M Health Care, St Paul, MN).

The study concluded that water-in-oil products containing petrolatum are more efficacious than oil-in-water products containing dimethicone in protecting the skin. However, dimethicone-containing products demonstrated higher hydration properties compared with petrolatum containing products. Despite the availability of skin care products, preventing skin insult and breakdown that is

secondary to urinary or faecal contamination, still remains a challenge.

Another study by Nix and Ermer-Seltun (2004) reviewed 76 perineal skin care protocols and the use of skin barrier products. Exposure to urine and faecal content can lead to perineal damage just as it may lead to peristomal skin damage. This damage may range in severity from erythema, swelling, oozing and vesiculation that may cause crusting and scaling. Protocols can improve the quality of care given to the patient where they can define the expected standards of prevention, care and treatment. However well written, protocols may be useless unless there is compliance. The reviews conclusion showed that many of the protocols were similar, yet lacked one or more interventions considered important in perineal skin care. 75% of the protocols included the use of skin protectants as part of the care.

Adhesive removal

When adhesive is keyed into the surface of the peristomal skin it can be removed by physically pulling, but this action will lead to the removal of loosely bound epidermal cell layers and strip the peristomal skin. This skin stripping alters the barrier property of the skin and exposes deeper skin cells, leaving the peristomal skin susceptible to attack from effluents such as faecal output and urine output from the stoma, bacteria and adhesive ingredients. Patients who physically remove their pouches with this action are more likely to suffer from peristomal skin breakdown (Lyons and Smith, 2003).

Adhesive removers fall into three categories:

1. Alcohol/organic-based solvents
2. Oil-based solvents
3. Silicone-based removers.

Table 1. Effects of alcohol-, oil- and silicone-based adhesive removers

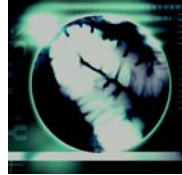
Negative effects	Alcohol	Oils	Silicones
Astringent effect on healthy and broken skin	Yes	No	No
Cooling effect on skin (evaporation of alcohol)	Yes	No	No
Dissolve hydrocolloids	Yes	Yes	No
Residue formed after use	Yes	Yes	No
Prolonged use damaging skin	Yes	No	No
Requires a secondary skin cleansing product	No	Yes	No
Positive effects	Alcohol	Oils	Silicones
Evaporates readily	Yes	No	Yes
Skin able to receive new appliance	No	No	Yes
Inert within the body	No	No	Yes

Source: Peace (2006); Berry et al (2007)

Table 2. Peristomal skin protective wipes (sterile/non sterile)

Product	Clinical need	Product features/ composition	Size	Shape	Material/ presentation	No. per pack (p per sachet)
Cavilon™ No-Sting Barrier Film, Wipe (3M Health Care, Bracknell, UK)	Primary barrier protecting skin from attack by body fluids	Hexamethyldisiloxane, iso-octane, acrylate terpolymer, polyphenylmethylsiloxane Forms protective film on skin surface via non-sting solvent. Reapply every 24–72 hours	29x29x3 mm	Foam square	Sterile sachet 1 ml solution	30 (78p)
LBF® No-Sting Barrier Film (Clinimed, Bucks, UK)	Primary barrier protecting skin from attack by body fluids	Hexamethyldisiloxane, siloxane copolymers, etc. Forms protective film on skin surface via non-sting solvent	96x158 mm folded to 50x25 mm	Non-woven fabric rectangle	Sterile sachet	30 (79.2p)
SkinSafe® Non-Sting Protective Wipe (Opus Healthcare Ltd, Colchester, UK)	Primary barrier protecting skin from attack by body fluids and adhesives	Hexamethyldisiloxane, blend of silicone co-polymers Forms protective film on skin surface via non-sting solvent	115x185 mm folded to 57x3 mm	Non-woven fabric rectangle	Non-sterile Sachet volume not stated	50 (71.4p)
Pelican Protect (Pelican® Healthcare, Cardiff, Wales)	Primary barrier protecting skin from attack by body fluids and adhesives	Hexamethyldisiloxane, blend of acrylate copolymers Forms protective film on skin surface via non-sting solvent	115x185 mm folded to 57x31 mm	Non-woven fabric rectangle	Non-sterile sachet Volume not stated	30 (78.6p)
OstoGuard™ No-sting Barrier Film (OstoMART Ltd, Nottingham, UK)	Primary barrier protecting skin from attack by body fluids and adhesives	Hexamethyldisiloxane, white oil, Lavender oil Non-sting	115x185 mm folded to 57x31 mm	Non-woven fabric rectangle	Non-sterile sachet Volume not stated	30 (65p)
CliniShield® Barrier Wipe (Clinimed, Bucks, UK)	Protect intact skin from attack by body fluids	Isopropyl alcohol etc. Not for use on sore/broken skin	75x155 mm	Rectangular	Non-sterile sachet	50 (27.3p)
Comfeel Protective Film (Coloplast Ltd, Peterborough, UK)	Protect intact skin from attack by body fluids	Ethoxy ethyl, methacrylic acid, ethyl acetate Not for use on sore skin	135x80 mm folded to 45x26 mm	Non-woven fabric rectangle	Non-sterile sachet Volume not stated	30 (35.3p)
ConvaCare® Protective Barrier Wipe (Convatec)	Forms protective barrier between appliance and skin	Ketone with film forming agent Not for use on sore/broken skin	30x68 mm folded to 30x35 mm	Non-woven fabric rectangle	Non-sterile sachet Volume not state	100 (17.0p)
Skin Gel Protective Dressing Wipes (Hollister, Wokingham, UK)	Prevents skin irritation due to adhesive appliances	Isopropyl alcohol, isopropyl polyvinyl methacrylate, methyl methacrylate, water, preservatives, etc.	45x25x1 mm	No-woven fabric rectangle	Non-sterile sachet Volume not stated	50 (26.7p)
Preventox Skin Protecting Film Wipe (Manfred Sauer UK Ltd, Northampton, UK)	Mainly for urinary sheaths. Prevents skin irritation due to adhesive	Ethyl alcohol with film-forming agent Not for use on sore/broken skin	36x40 mm folded to 36x40 mm	Non-woven fabric rectangle	Non-sterile sachet Volume not stated	50 (17.4p)
Rüsch Translet Barrier Wipe (Teleflex Medical UK, High Wycombe, UK)	Forms protective barrier between appliance and skin	Isopropyl alcohol, polyvinyl acetate, propylene glycol Not for use on sore/broken skin	82x150 mm folded to 41x25 mm	Non-woven fabric rectangle	Non-sterile sachet Volume not stated	30 (20.5p)
Peri-Prep® Wipe (Salts Healthcare, Birmingham, UK)	Protects skin when used under ostomy appliances	Isopropyl alcohol containing film-forming agent Not for use on sore/broken skin	30x70 mm folded to 30x35 mm	Non-woven fabric rectangle	Non-sterile sachet Volume not stated	50 (33p)
Derma-Gard Skin Wipe (Mentor)	Forms protective barrier between appliance and skin	Isopropyl alcohol, butylpolyvinyl methacrylate, methyl methacrylate, water, preservatives etc.,. Not for use on sore/broken skin	28x70 mm folded to 28x3 mm	Non-woven fabric rectangle	Non-sterile sachet Volume not stated	50 (32p)

Source: Smith (2007)

**Table 3. Adhesive remover wipes**

Product	Clinical need	Product features/ composition	Size	Shape	Material/ presentation	No. per pack (p per sachet)
Appeel™ no-sting medical adhesive remover wipes (Clinimed)	Removal of adhesive appliances/adhesive residue from broken skin	Hexamethyldisiloxane, etc. Highly effective medical adhesive remover. Safe for use on broken skin	95x165 mm folded to 47x25 mm	Non-woven fabric rectangle	Sachet containing impregnated non-woven fabric wipe	30 (49p)
Lift Plus non-sting medical adhesive remover wipes (Opus Healthcare Ltd)	Removal of adhesive appliances/adhesive residue from broken skin	Hexamethyldisiloxane and Aloe Vera. Highly effective medical adhesive remover. Safe for use on broken skin	108x185 mm folded to 52x31 mm	Non-woven fabric rectangle	Sachet containing impregnated non-woven fabric wipe	30 (47.3p)
Comfeel® Cleanser adhesive remover wipes (Coloplast Ltd)	Removal of adhesive appliances/adhesive residue from intact skin	Isopropylalcohol, detergents, preservatives, fragrance and water. Cleanses, refreshes, softens skin exposed to body fluids. Not for use on sore skin.	190x195 mm folded to 50x30 mm	Non-woven fabric rectangle	Sachet containing impregnated non-woven fabric wipe	30 (28.9p)
Convacare® Adhesive Remover Wipe (Convatec)	Removal of adhesive	Oilly lotion	68x30 mm folded to 35x30 mm	Non-woven fabric rectangle	Sachet containing impregnated non-woven fabric wipe	100 (17p)
Universal remover wipes for adhesives and barriers (Hollister)	Removal of adhesive appliances/adhesive residue from intact skin	Alcohol, ethyl acetate, detergents, fragrance and water. Removes tapes etc and adhesive residue from the skin. Not for use on sore skin	34x49x1 mm	Non-woven fabric rectangle	Sachet containing impregnated non-woven fabric wipe	50 (26p)
Lift Medical Adhesive Remover Solution (Opus Healthcare Ltd)	Removal of adhesive appliances/adhesive residue from intact skin	Orange oil and Aloe Vera. Medical adhesive remover	105x180 mm folded to 60x30 mm	Non-woven fabric rectangle	Sachet containing impregnated non-woven fabric wipe	30 (29p)
Ultra Cleanse Skin Cleanser (Opus Healthcare Ltd)	No rinse skin cleanser	Isopropyl alcohol, Aloe Vera, preservative, perfume. Not for use on sore/broken skin	N/A	N/A	Sachet containing fluid only	30 (28.4p)
OstoClear™ Medical Adhesive Remover (OstoMART Ltd)	Removal of adhesive appliances/adhesive residue from intact skin	Paraffin, hydrocarbons, mineral Oil, Tea Tree oil, Lavender oil. Medical adhesive remover. Use on sore/broken skin	105x185 mm folded to 31x55 mm	Non-woven fabric rectangle	Sachet containing impregnated non-woven fabric wipe	30 (28.5p)
Citrus Fresh Adhesive Remover (Pelican® Healthcare Ltd)	Removal of adhesive appliances/adhesive residue from intact skin	Orange oil and Aloe Vera. Medical adhesive remover. Use on sore/broken skin	105x180 mm folded to 60x30 mm	Non-woven fabric rectangle	Sachet containing impregnated non-woven fabric wipe	30 (29.5p)
WipeAway™ Adhesive Remover (Salts Healthcare)	Removal of adhesive appliances/adhesive residue from intact skin	Aliphatic hydrocarbons, fragrance. Medical adhesive remover. Use on intact skin	105x155 mm folded to 30x5 mm	Non-woven fabric rectangle	Sachet containing impregnated non-woven fabric wipe	30 (28.8p)

Source: Smith (2007)

Alcohol/organic-based solvents

The use of alcohol-based products to remove adhesives such as stoma appliances relies on the alcohol to dissolve the components of the adhesive as opposed to reducing the bond strength. With advanced technological products available today, removing adhesives with alcohol is dated and inefficient. Also the astringent effect of alcohol may cause drying, irritation and pain if it comes into contact with broken peristomal skin (Berry et al, 2007).

Oil-based solvents

Oil-based solvents work by 'wicking' into the interface of skin and adhesive and releasing the bond. These solvents are based on paraffin, which are simple mixtures or more complex mixtures using citrus oil extracts. The problem with using oil-based solvents is that the new appliance will not stick to oily skin, thus causing leakage through ineffectual bonding or not adhering to the peristomal skin at all. After using oil-based solvents the peristomal skin must be washed thoroughly with soap and water to remove all traces of oil. When travelling or at work it may not always be possible to wash the peristomal skin at each appliance change after using an oil-based solvent which will then cause a problem for the patient in using a new appliance (Berry et al, 2007).

Table 4. Possible causes of peristomal skin irritation

Faecal leakage

- Ill-fitting appliance
- Poorly sited stoma
- Scars close to the stoma
- Complicated stoma

Mechanical irritation

- Adhesive
- Kinking of adhesive material
- Cleaning soaps and materials
- Other substances used to clean skin

Allergy/hypersensitivity

- Any substance that comes into contact with the peristomal skin
- Substances used to clean the skin
- Skin preparations

Sweating

- Fungal
- Bacterial

Pre-existing skin disease

- Eczema
- Psoriasis
- Pyoderma

(Black, 2000)

Table 5. Interventions for the prevention of peristomal skin problems

- Appliance changes should be undertaken regularly as advised and immediately if there is any suspicion of leakage of faeces, effluent or urine
- Establish a time of day when it is best for the patient to change his or her appliance
- Peel back flange without causing friction to the skin by using a silicone-based adhesive remover
- Cleanse peristomal skin using a pH-balanced surfactant, soft cloth and warm water
- After gently drying with a soft cloth, apply a silicone-based skin barrier in the form of wipes, spray, lotion, cream or gel
- Allow a few seconds for the barrier to dry
- Select the correct type of appliance for the stoma, with a hydrocolloid-based flange and apply to the clean skin

Source: Black (2000); Nix and Ermer-Seltun (2004)

Silicone-based removers

Hexamethyldisiloxane (silicone) in the form of an adhesive remover rapidly penetrates the adhesive-skin bond by spreading effectively and rapidly on the peristomal skin surface, penetrating the interface to form an interposing layer. This type of adhesive remover is the product of choice to aid the removal of stoma appliances for patients and for healthcare professionals. It has also been observed that an adhesive remover such as this is effective for the removal of urinary sheaths and dressings where trauma to delicate skin may occur (Cutting, 2006). Table 1 shows the effects of the three types of adhesive removers. (A full list of organic-, oil- and silicone-based sterile, and non-sterile, skin protective products, as well as adhesive removers, can be found in Tables 2 and 3.)

Because the skin provides protection against physical and chemical agents, and bacterial invasion such as effluent, urine and skin stripping – especially in stoma care – it is imperative that the peristomal skin is protected (Borwell, 1996; Black, 2000; Porrett and McGrath, 2005). Table 4 shows the possible causes of peristomal skin irritation that should be investigated before the use of barrier creams, lotions, wipes and sprays are applied. Once the cause has been ascertained the appropriate peristomal skin protector can be applied.

Skin cleansing

Within a good skin care protocol, designed and understood by patients and healthcare professionals alike, the patient at risk from the breakdown of peristomal skin from effluent, urine or chemicals, will not be disadvantaged.

Cleansing should not compromise the peristomal skin. Soaps that are harsh, containing carbohcic, disinfectant or other chemicals, should not be used to wash the peristomal

skin area. Products such as these will strip away the stratum corneum lipids and proteins. Such products should have milder surfactants and more phospholipids. Skin cleansers that are combined with moisturizers may help to repair and replace the barrier that is disturbed when cleansing takes place. Limiting the frequency of soaps, especially bar soaps and using foam and liquid soaps applied with a soft cloth and water that is not too hot, will help in the reduction of peristomal skin stripping (Hachem et al, 2003; Fore, 2006).

A skin cleanser that has a pH of 5.5 is the most suitable as a cleanser surfactant (a surface active agent that is a substance that when dissolved in water gives a product that has the ability to remove dirt). Many cleanser surfactants can cause the feeling of tightness of the skin after application and removal due to the stripping of the lipids and protein alteration in the stratum corneum. This will then lead to peristomal skin damage, water loss from the skin, irritation and itchiness resulting in erythema of varying degree. The action of a mild skin cleanser should provide the benefit of moisturizing and cleansing the skin without altering the hydration and elastic properties of the skin (Fore, 2006).

Patients who suffer from damaged, painful peristomal skin will have quality-of-life (QoL) issues. Damaged peristomal skin often prevents appliances sticking, therefore causing distress to the patient and the inability of the patient to continue with their day-to-day activities such as working, care of the family and socializing. Fear, anxiety, embarrassment and depression are also factors that can affect the QoL of stoma patients who have problems with appliance attachment.

In 1997 the Montreux QoL study of stoma patients was set up in sixteen European countries enrolling in excess of 5289 patients. The domain pertaining to appliance

change showed that a decrease in patient confidence came when there were peristomal skin problems, resulting in a lower patient confidence and decreased QoL score (Black, 2000). Pain due to erythema of peristomal skin damage can limit patients' mobility and should not be underestimated.

An observation index to help healthcare professionals compare skin conditions has been compiled and is available from Dansac (2002). The index was a project initiated by Dansac through the International Ostomy Forum group that was made up of six experienced stoma care nurses from the UK. The object is to enable nurses to identify stoma and skin conditions through a picture and word index to enable the to help prevent problems arising both pre and post surgery.

Conclusion.

Evidence-based care, the conscientious, explicit and judicious use of current best evidence in decision-making regarding the care of individual patients, and the use of peristomal barrier creams, lotions, wipes, sprays and gels, has been examined in this article (Sackett and Haynes, 1995). A range of studies show the value of silicone-based products for peristomal barriers and adhesive removers and that these are the ones that will give the patient a better QoL (Brewster, 2004; Issberner and Schuren, 2004; Nix and Emer-Seltun, 2004; Rolstad and Erwin-Toth, 2004; Hoggarth et al, 2005; Turnbull, 2005, 2006; Cutting, 2006; Fore, 2006; Herlufsen et al, 2006; Berry et al, 2007).

Protocols help to improve patient care and they define expected standards of care and also serve as educational tools for healthcare professionals (Fenner, 1996). A suggested protocol is shown in Table 5. Often stoma care compliance is more likely to occur when the patient accepts and likes the products used, both as the peristomal skin protector, adhesive

remover and pouch. The importance of using the correct barrier cream or spray and adhesive remover cannot be underestimated: they have enabled patients to live a full and productive life, by preventing the occurrence of peristomal-related problems and decreasing the patients QoL (Berry et al, 2007).

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KEY POINTS

- Frequent appliance changes and removal of adhesives can damage peristomal skin by stripping away the outer epidermal layers.
- People most at risk are the aged and neonates due to their thinning (older people) and thin (neonates) skin.
- Silicone-based peristomal skin barriers and adhesive removers ensure skin friendliness.
- The failure of healthcare professionals to recognize the difference between alcohol-, oil- and silicone-based peristomal skin protectors and adhesive removers, may lead to unnecessary peristomal skin problems for the patient.
- The use of a protocol aids healthcare professionals and patients to reach a defined standard for prevention and care of their peristomal skin.