



Loop colostomy formation with a skin bridge technique in a gynecological oncology center

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Our objective was to demonstrate formation of loop colostomy, secured using a skin bridge technique, as part of emergency bowel diversion in a gynecological oncology center. Using videography, we have demonstrated the selection of a segment of large bowel and the maturing of a loop colostomy on the abdominal wall, secured using a skin bridge technique as part of the emergency management of a bowel perforation 7 days after total abdominal hysterectomy, bilateral salpingo-oophorectomy and omentectomy.

A step-by-step process, accompanied by intra-operative videography, is presented. The stoma site is prepared with dissection of the skin bridge tissue followed by division of the bridge to allow the bowel loop to pass through. The abdomen is entered through the same incision and a section

of colon is brought out through a cruciate rectus sheath incision to form the loop stoma. When the bowel loop is positioned, the skin bridge is passed through a mesenteric window and is secured with a 2–0 polydioxanone mattress suture. After routine abdominal closure and wound dressing, the bowel loop is incised to complete stoma formation and the mucosal edges are secured to the skin with 3–0 poligleaprone (monocryl) sutures.

Skin bridge loop stoma formation compares favorably with fashioning of the stoma over a synthetic rod removed on postoperative days 7–10. The glass or plastic prosthesis interferes with the fitting of the stoma plate, and increases peristomal complications.¹ We have previously demonstrated that patients with stomas secured with skin bridge techniques had

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Video 1 Demonstration of formation of a skin bridge loop colostomy secured with a skin bridge technique as part of the management of postoperative bowel injury.



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Figure 1 Satisfactory formation of a loop colostomy secured with the skin bridge technique; skin markings for alternate site are visible cranially.

decreased delays to stoma self-care.² In the largest series comparing 45 skin bridge and rod loop stomas, skin bridge use was associated with significantly reduced inflammatory skin complications and improved quality of life.³ The long term support offered by the skin bridge technique is of particular interest in gynecologic oncology where disease

progression may lead to mesenteric shortening and late stomal retraction.

Skin bridge loop stoma formation (Figure 1) is safe and feasible for both emergency and elective bowel diversion, where it provides for more rapid stoma self-care and reduced complications postoperatively.

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