

COMMON OSTOMY RELATED SURGERIES OF THE COLON & RECTUM

SURGICAL PROCEDURE	DESCRIPTION	TYPE OF STOMA	INDICATIONS
Abdominal perineal resection of the rectum with end descending colostomy (AKA APR/Miles procedure)	Wide resection of the rectum, surrounding tissues and lymph nodes via an abdominal and perineal approach. Abdominal and perineal wounds present	Permanent End descending Colostomy	Very low rectal cancer
Low Anterior Resection (LAR)	Wide resection of the upper rectum; colon and distal rectum anastomosed	Usually no stoma	Cancer in mid to upper rectum
Low Anterior Resection (LAR) plus Colonic J-pouch	Wide resection of the upper rectum; a colonic reservoir (J-pouch) is formed to anastomosed to rectum	Temporary loop ileostomy x 3 months to allow distal anastomosis to heal	Cancer in mid to upper rectum
LAR with Colooplasty	Wide resection of the upper rectum. Distal colon cut longitudinally then sewn transversely to expand capacity	May or may not require temporary loop ileostomy	Cancer in low-mid to upper rectum
Hartmann's Procedure	End stoma is created from proximal bowel; distal bowel is closed and remains in pelvis. Will have mucus drainage from rectum	End colostomy Potential for re-anastomosis	Diverticulitis, obstruction, perforation
Colectomy	Colon removed usually primary anastomosis	Usually no stoma needed	Crohn's Disease Colon cancer Diverticular
Subtotal Colectomy	Most of colon removed usually primary anastomosis, but may have end ileostomy with subsequent restorative procedure possible	Usually no stoma needed	Crohn's Disease Colon cancer Diverticular disease
Left Hemicolectomy	Left colon resected usually primary anastomosis	Usually no stoma needed	Crohn's Disease Colon cancer Diverticular disease
Right Hemicolectomy	Right colon resected usually primary anastomosis	Usually no stoma needed	Crohn's Disease Colon cancer Diverticular disease

SURGICAL PROCEDURE	DESCRIPTION	TYPE OF STOMA	INDICATIONS
Ileoanal anastomosis	Colon and rectum are removed. Ileum connected to anal canal	None	Not recommended Intractable diarrhea Rarely considered in MUC, FAP or atonic colon
Total proctocolectomy with end ileostomy (AKA pan proctocolectomy)	Colon, rectum and anus removed. Perineum closed	Permanent end ileostomy	MUC, Crohn's Disease, FAP
Total proctocolectomy with continent ileostomy	Colon, rectum and anus removed. Internal intestinal reservoir created from distal ileum. Continence achieved by intussusception of bowel in efferent limb	Flush end Ileostomy; must insert catheter into stoma to drain internal reservoir	MUC, FAP
Ileal pouch anal anastomosis (IPAA)	Usually done in 2 stages:		MUC, FAP
A. Ileoanal reservoir (Total proctocolectomy with ileal pouch anal anastomosis) (AKA Pelvic pouch, J-pouch, S-pouch)	Stage 1 Colon and most of rectum removed, pouch constructed from distal ileum; anastomosed to rectal stump; proximal loop ileostomy	Temporary loop ileostomy (usually 3 months)	
	Stage 2 Take down of loop ileostomy (stoma closure) (If patient unstable may be done in 3 stages with a subtotal colectomy & end ileostomy first, followed by Stages 1 & 2 as noted above)	No stoma, patient evacuates per anus	

COMMON OSTOMY RELATED SURGERIES OF THE URINARY TRACT

SURGICAL PROCEDURE	DESCRIPTION	TYPE OF STOMA	INDICATIONS
Ileal conduit (AKA Bricker loop)	Bladder usually removed. A 6-8" segment of terminal ileum is isolated. Mesentery left intact. Ureters implanted into ileal segment, proximal end closed; distal end brought up as abdominal stoma	End or loop end ileal conduit (ileal segment acts as a conduit for urine)	Bladder cancer, congenital anomalies, neurogenic bladder, other
Jejunum conduit	Same as above only segment of jejunum is used	End or loop end jejunum conduit	Used only if ileum not available
Sigmoid conduit	Same as above only segment of sigmoid colon is used. Able to tunnel ureters to prevent reflux	End or loop end sigmoid conduit. Larger stoma than with ileal or jejunum conduit	Used only if ileum not available
Continent urostomy: Ileal cecal reservoir (AKA Indiana Pouch)	Bladder usually removed; portion of terminal ileum, cecum and right colon isolated and reservoir formed and ureters implanted to prevent reflux. Continence achieved through ileo-cecal valve and plication of exit conduit	End stoma; Stoma is very small and may be brought through to umbilicus. Must insert catheter into stoma to drain	Same as for ileal conduit
Continent urostomy: Kock Pouch (Urinary K-pouch)	Bladder usually removed. Segment of terminal ileum is isolated. 2 nipple valves fashioned - ureters implanted into 1 to prevent reflux; the other valve brought to the abdomen and stoma formed	End stoma requires insertion of catheter to drain the reservoir	Same as for ileal conduit

OROTHOTOPIC URINARY DIVERSIONS

SURGICAL PROCEDURE	DESCRIPTION	TYPE OF STOMA
Studer Pouch	Bladder removed; reservoir constructed from isolated ileal segment Anti reflux achieved by passing ureters through 15 - 20cm of afferent ileum	No stoma Continence achieved with external urethral sphincter
LeBag	Bladder removed; reservoir constructed from isolated segment of ileum and cecum Ureters tunneled to prevent reflux neobladder sutured to urethra	No stoma Continence achieved with external urethral sphincter