ASK the Pharmacist

Q:

My spouse is going to undergo surgery to remove part of his intestines. Can you tell me a little about this and any recommendations you have about the current medications he uses and how they might be impacted?

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A:
An ostomy is a surgical procedure that creates an opening in the abdomen that allows for fecal waste products to exit the intestines into a bag rather than be excreted through the defecation process as they would normally be. In the United States, it is estimated that 120,000 to 130,000 ostomy surgeries are performed annually and it is reasonable to assume that the rate is pretty much the same here in Canada. While many people dread the word, ostomies are performed only when the underlying medical condition is so severe that the operation should provide a much better quality of life. An ostomy is done when a portion of the bowel is surgically removed (to remove the disease or a permanently damaged part) and the bowel left over cannot be reconnected (a procedure known as re-anastomosed). The most common reason people undergo this is usually a result of diseases of the gastro-intestinal (GI) tract such as Crohn's disease, ulcerative colitis, colon cancer, diverticulitis, an obstruction in the intestines and fecal incontinence. Trauma such as from a car accident for example can also be a culprit. After the surgery, people wear an appliance with a pouch over the opening (known as a stoma) on their abdomen that collects fecal waste. An ostomy can be performed at any point along the GI tract and the exact location and amount of intestine removed depends upon the condition being treated and the extent of the damage. An ileostomy is formed when the entire colon is removed. If only a portion is cut out, the procedure is referred to as a colostomy. Ostomies can be permanent or temporary. A temporary ostomy is created in order to divert fecal flow and allow areas healing time for portions of the intestine located further along the tract. A temporary ostomy may be required for several months or even longer after which surgery is performed again to reattach the now healed intestine back together again. Ostomies are not always required after the surgical removal of intestinal tissue even when the sections cannot be reattached. One such surgical procedure is called an ileoreservoir where an internal pouch is created eliminating the need for a stoma. When it comes to drug therapy, deciding which existing drugs need to be altered depends upon the site of the ostomy, the length and health of the remaining bowel and a number of factors related to the medication itself. In general, only drugs that are swallowed or taken through the rectum may need to be reconsidered. Administering a drug via a suppository should be avoided in both colostomy and ileostomy patients while the enema dosage form may be a possibility in those with a colostomy but is not suitable for ileostomy patients. When it comes to oral medication, not surprisingly liquids, chewable tablets, orally disintegrating tablets (i.e. the ones that dissolve under your tongue such as Ativan sublingual tablets are all unlikely to be an issue. Tablets that are film coated (often done to mask a powdery taste) such as Tylenol and Advil (which may not be appropriate depending on the underlying disease state that caused all of this in the first place) are usually okay in both surgeries as are enteric coated tablets (such as a coated Aspirin) in colostomies although the latter may need to be changed in ileostomy patients depending on where about in the intestine the tablet is designed to actually release the medication. Drugs that are sustained release or long acting are usually not going to work well for ileostomy patients and may need to be changed in those with colostomies as well. Patients should report intact tablets that appear in their pouch to their health care practitioners as well as any signs of blood that may appear within it. It should be noted as well that drugs can affect the output from the stoma just as they do in us. In other words, drugs can increase or decrease the fecal output just as they may cause diarrhea or constipation within the rest of us. As well, some drugs can change the colour and smell of the ostomy output which, once again, is an effect that can be seen in anybody else taking the same medication. As far as over the counter drugs go, antacids containing calcium or aluminum would be preferred to magnesium ones that are more likely to result in diarrhea. With laxatives, bulk-forming ones (e.g. Metamucil/ psyllium) should be avoided in ileostomy patients and stimulant (senna)/ osmotic (PEG/ Restoralax…) ones used only with caution due to the potential for dehydration and electrolyte abnormalities. Most oral laxatives are safe to use in colostomy patients although the stimulant/ osmotic ones should be saved as last resorts. The anti-diarrheal loperamide (Imodium) is used in ileostomies on a regular basis to decrease fecal output when necessary and can also be used in colostomies. Care should also be paid to monitor for constipation or a possible obstruction. If you are in doubt about a medication, the safest thing to do is run it by your pharmacist who can then contact the prescriber if need be. For more information about this or any other health related concerns, contact the pharmacists at Gordon Pharmasave, Your Health and Wellness Destination.

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