PROCEDURE

Ileostomy

An ileostomy is surgery that brings the small intestine through the abdomen so stool can leave through a stoma.

PURPOSE
Divert stool through an abdominal opening to protect or bypass bowel

PROCEDURE TYPE
Therapeutic surgery, performed open or minimally invasively

WHERE IT IS DONE
Operating theatre

ANAESTHESIA
General anaesthesia

HOW LONG IT TAKES
About 1-3 hours; longer when combined with bowel removal

PREPARATION
Fasting, medication review, and sometimes bowel preparation

RECOVERY
Several hospital days; no driving until safe and off opioids

MAIN RISKS
Dehydration, blockage, skin damage, stoma or wound problems

RESULTS
Stoma functions within days; pathology follows if tissue was removed

Overview

An ileostomy is an opening made during surgery between the ileum-the last part of the small intestine-and the skin of your abdomen. The visible opening is called a stoma . Stool and digestive fluid leave through the stoma and collect in a pouch worn outside your body.

An ileostomy may be temporary or permanent. A temporary ileostomy allows another part of the bowel to rest or heal. A permanent one is used when the bowel cannot be safely reconnected or when the colon and rectum have been removed.

A loop ileostomy is often temporary and usually has two openings within one stoma. An end ileostomy uses the end of the small intestine and may be temporary or permanent.

The ileostomy may be the main operation or one part of a larger procedure, such as removal of

the colon.

Why the procedure is performed

An ileostomy redirects stool away from the colon, rectum, anus, or a healing bowel connection. It may be recommended to:

Your surgeon should explain why an ileostomy is being considered, whether it is expected to be temporary, and what would need to happen before a possible reversal.

- Protect a new bowel connection while it heals
- Treat or prevent complications from inflammatory bowel disease
- Allow removal of bowel affected by cancer or another serious condition
- Manage a bowel blockage, perforation, injury, or severe infection
- Restore a route for stool when it cannot safely pass through the anus

Who should and should not have it

An ileostomy may be appropriate when redirecting stool is safer than keeping the usual route through the colon and rectum. The decision is based on your underlying condition, the health of your bowel, previous operations, and your overall ability to undergo surgery.

It is not the right option for everyone. It may be avoided when the bowel can be safely treated or reconnected without a stoma. Planned surgery may be delayed, when medically safe, to improve severe dehydration, poor nutrition, uncontrolled infection, or another condition that raises the risk of anaesthesia or healing problems.

The planned stoma location may need to change if scars, skin folds, a hernia, or active skin disease would prevent a pouch from sealing well. A specialist stoma nurse can assess and mark the best position while you sit, stand, and bend.

Some ileostomies are created during emergency surgery, when there is less time for preparation. In that situation, the immediate need to treat a blockage, perforation, or serious infection may outweigh reasons to delay.

How to prepare

Your treating facility's own instructions take priority because preparation differs according to

the operation being performed.

You will usually be told when to stop eating and drinking before general anaesthesia. Some people need bowel preparation to empty the intestine, while others do not.

Give the surgical team a current list of medicines, supplements, allergies, and previous reactions to anaesthesia. Ask specifically about blood thinners like warfarin or apixaban , diabetes medicines, and medicines that affect the immune system. Do not stop prescribed treatment unless your team tells you to.

Before planned surgery, you may have blood tests, imaging, or an anaesthetic assessment. A stoma nurse may mark the proposed site and show you how a pouch works. It can help to plan transport home and arrange support for shopping, meals, or lifting during early recovery.

What happens during the procedure

You receive general anaesthesia, so you are unconscious and do not feel the operation.

The surgeon may use one larger incision in an open operation or several small incisions during minimally invasive surgery. The approach often reflects the underlying condition and whether other bowel surgery is needed.

A section of ileum is brought through an opening in the abdominal wall. The surgeon turns its edge back slightly and stitches it to the skin to form a moist, pink or red stoma. Because a stoma has no voluntary closing muscle, output empties into an attached pouch.

The surgeon may remove diseased bowel, close the downstream bowel, or create a new bowel connection during the same operation. A temporary loop ileostomy may be supported briefly with a small bridge or rod.

The stoma is usually swollen after surgery. Its size changes as swelling settles, so the pouch opening needs regular measurement at first.

Recovery and what to expect afterward

Pain is expected around the abdominal incisions, although the stoma itself has little or no pain sensation. Pain relief is provided and should gradually become less necessary.

You will usually begin with fluids and move toward food as your bowel starts working. Ileostomy output is often liquid at first and may thicken over time. Your team will explain how much to drink, how to replace salt, and which foods may be easier during early recovery.

Walking soon after surgery helps circulation and bowel recovery. Avoid heavy lifting and

strenuous abdominal activity until your surgeon says the wounds have healed. A stoma nurse will teach you how to empty and replace the pouch and protect the surrounding skin.

Do not drive while taking opioid pain medicine or until you can move comfortably, wear a seat belt, check blind spots, and perform an emergency stop. Follow your insurer's requirements as well as your surgical team's advice.

Returning to work often takes several weeks. Timing is influenced by the larger operation, wound healing, your energy level, and whether your job involves lifting or physical labour.

Risks and possible complications

Possible risks include those of abdominal surgery and those specific to a stoma:

These problems are not inevitable. Correct pouch fitting, attention to fluid intake, and early advice about changes in output or stoma appearance can reduce their effect.

- Bleeding, infection, blood clots, or anaesthesia complications
- Dehydration or changes in body salts from high ileostomy output
- Bowel blockage from swelling, scar tissue, or difficult-to-digest food
- Sore or damaged skin caused by leakage around the pouch
- A stoma that becomes narrowed, retracts, protrudes, or loses blood supply
- A hernia beside the stoma
- Poor wound healing or leakage from another bowel connection
- Reduced kidney function if fluid losses are not replaced

Results and follow up

The immediate result is a new route for stool. The stoma usually begins producing gas and liquid output within the first few days. If bowel tissue was removed, laboratory results may take several days or longer.

Routine follow-up checks your wounds, hydration, nutrition, pouch fit, and stoma function. Contact your stoma nurse between visits if repeated leaks or skin soreness make the pouch difficult to manage.

If the ileostomy was intended to be temporary, reversal is a separate operation. Before offering it, the surgeon may check that the bowel connection has healed and that you are fit for

more surgery. A temporary plan does not guarantee that reversal will be possible or advisable.

Alternatives

Alternatives are shaped by why surgery is being considered.

A bowel resection with immediate reconnection may avoid a stoma, but the connection can leak. An ileostomy may be recommended when that risk is considered too high or when a connection needs protection.

A colostomy redirects the large intestine instead. Its output is often more formed, but it is only possible when suitable colon remains and fits the surgical plan.

For selected people, an internal pelvic pouch made from small intestine can allow stool to pass through the anus. This requires major surgery and can lead to frequent bowel movements, leakage, or inflammation of the pouch.

Medicines, endoscopic treatment, drainage procedures, or observation may sometimes delay or avoid surgery. These options do not correct every blockage, perforation, cancer, or severely damaged bowel. Choosing no operation may also be reasonable in some circumstances, but it may leave the underlying problem untreated. Ask what each option means for symptoms, future surgery, and overall goals of care.

When to call your healthcare team

Contact your surgical or stoma team promptly for:

Seek urgent medical assessment for severe abdominal cramps with vomiting and little or no stoma output, significant bleeding into the pouch, or a stoma that becomes dark, grey, or black.

Call emergency services for fainting, severe breathing difficulty, chest pain, confusion, uncontrolled bleeding, or another rapidly worsening condition. Routine questions about supplies, diet, work, or planned reversal can usually wait for normal clinic hours.

- Output that is repeatedly much higher or more watery than expected
- Persistent pouch leakage, worsening skin damage, or wound drainage
- Increasing redness, swelling, pain, or fever
- Signs of dehydration, such as marked thirst, dizziness, dark urine, or reduced urination
- A new bulge, narrowing, retraction, or marked protrusion of the stoma

Common questions

Will I be asleep?

Yes. An ileostomy is created under general anaesthesia, so you are unconscious during the operation.

Can I drive home?

No. You will remain in hospital after surgery and need someone else to take you home. Do not resume driving until you are off impairing pain medicine and can control the vehicle safely.

How painful is it?

The incisions and deeper abdominal tissues can be painful, especially during the first few days. The stoma itself usually does not hurt when touched, but the skin around it can become sore if output leaks underneath the pouch.

When will I know whether it worked?

The stoma usually begins passing gas and output within days. Whether the larger operation achieved its goal may be clear immediately or may require recovery, imaging, or pathology results.

Will I always need a bag?

A functioning ileostomy always needs a pouch. If the ileostomy is temporary and later reversed, you will no longer need it. Reversal is not possible or appropriate for everyone.

Can I eat normally afterward?

Most people gradually return to a broad diet. Early advice often focuses on chewing well, adding foods slowly, drinking enough, and watching how particular foods affect output or blockage risk.

Sources

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