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Quality of life and self-esteem of patients with intestinal stoma

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ABSTRACT

The aim of this study was to investigate the quality of life and self-esteem in patients with intestinal stoma. This is a clinical, primary, descriptive, analytical study, conducted at the Ostomized People's Pole of Pouso Alegre, after approval by the Ethics Committee of the Faculdade de Ciências da Saúde Dr. Jose Antonio Garcia Coutinho under opinion No. 23,227. Three instruments – a questionnaire on demographics and stoma, Rosenberg Self-Esteem Scale/UNIFESP-EPM and Flanagan Quality of Life Scale – were used in the data collection. The following tests were used for statistical analysis: chi-squared and Kruskal–Wallis tests and Spearman correlation. For all statistical tests, the level of significance of 5% ($p < 0.05$) was considered. Most participants were older than 60 years, of male gender and attended support groups. Twenty-one (30%) of respondents were illiterate. Neoplasia was the most frequent of the causes that led patients to receive an ostomy; permanent colostomy was the type of ostomy used. Individuals were not submitted to stoma demarcation and did not make irrigation. Regarding the type of complication, 34 (48.60%) had dermatitis; 14 (20%) showed retraction.

The mean of Rosenberg Self-Esteem Scale/UNIFESP-EPM was 10.81 and the mean of Flanagan Quality of Life Scale was 26.16. It was concluded that individuals with intestinal stoma participating in the survey showed impaired self-esteem/quality of life.

Qualidade de vida e autoestima em pacientes com estoma intestinal

Palavras-chave:
Estomia
Qualidade de vida
Imagem corporal
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Autoestima

RESUMO

O objetivo deste estudo foi investigar a qualidade de vida e a autoestima em pacientes com estoma intestinal. Trata-se de um estudo clínico, primário, descritivo e analítico. Este estudo foi realizado no Pólo dos ostomizados de Pouso Alegre, após aprovação pelo Comitê de Ética em Pesquisa da Faculdade de Ciências da Saúde "Dr. José Antônio Garcia Coutinho", sob o parecer no 23.277. Foram utilizados três instrumentos para a coleta de dados da pesquisa: questionário sobre os dados demográficos e estoma, Escala de Autoestima de

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Rosenberg/UNIFESP–EPM e Escala de Qualidade de Vida de Flanagan. Foram utilizados para a análise estatística os seguintes testes: Qui-quadrado e Kruskal-Wallis e correlação de Spearman. Para todos os testes estatísticos, foi considerado o nível de significância de 5% ($p < 0,05$). A maioria dos participantes tinha mais de 60 anos, eram do gênero masculino e participavam de grupo de apoio. Vinte e um (30%) dos participantes da pesquisa eram analfabetos. Neoplasia foi a causa mais frequente para a aquisição da ostomia; o tipo de ostomia foi colostomia permanente. Os indivíduos não foram submetidos à demarcação do estoma e nem realizaram irrigação. Com relação ao tipo de complicação, 34 (48,60%) apresentavam dermatite; 14 (20%) retração. A média da Escala de Autoestima de Rosenberg/UNIFESP–EPM foi 10,81 e a média da Escala de Qualidade de Vida de Flanagan (EQVF) foi 26,16. Concluiu-se que os indivíduos com estoma intestinal que participaram da pesquisa apresentavam autoestima e qualidade de vida prejudicadas.

Introduction

A stoma is an artificial communication between organs or viscera and the external environment, for feeding, drainage and elimination. The making of an ostomy is a medical-surgical procedure. With respect to the origin of the disease, the ostomy may be temporary or permanent.[1]

When receiving a stoma, the individual begins to evacuate through the artificial communication installed in his/her abdomen. At first, many patients would rather die than live with the stoma. Over the days, they start to realize that having an ostomy means gaining the opportunity for a new life. In this sense, it is noticed that, after an ostomy, individuals thus treated experience moments of emotional or psychological change that, by affecting the quality of life, self-esteem, body image and even their sexuality, can generate anxiety and even depression.

We observe the loss of social status due to the isolation imposed by the ostomized individual him(her)self and by the society, which can reject those who are considered outside the so-called normal patterns, that is, those who do not have a body that fits the current beauty and biomedical functioning parameters.[2]

Living with a stoma often causes feelings of fear, anguish and insecurity; these people believe that they are not able to return to their activities of life after hospitalization. It must be emphasized that the process of rehabilitation of ostomized people begins preoperatively and continues with their return home, when a new phase starts, marked by profound biological, psychosocial and economic changes, and whit a new battle which ought be fought by the ostomized person to cope with, and survive to, the new conditions.[3]

Quality of life (QOL) is the individual's perception of his/her health status in relation to social, physical, psychological, economic and spiritual aspects.[4,5]

The World Health Organization (WHO) defines QOL covering five dimensions: physical health, psychological health, level of independence, social relationships and environment.[6]

Thus, the quality of life and well-being encompass the observations needed to the research on ostomized patients, referring to the person's physical health, level of independence, social relationships, psychological state, personal beliefs and relationship with key aspects of the environment, which may cause changes in self-esteem and self-image, triggering anxiety and depression.[7–9]

The assessment of self-esteem in ostomized people is becoming increasingly important and necessary, because when subjected to this surgery, these people start living a different experience, where their standard of living and rhythm of life begin to change. Their desires and values are often not fulfilled nor respected; they feel rejected, seeking seclusion because of the odor and elimination of feces through the abdomen.

Notwithstanding the recognition of the importance of self-esteem to social and individual well-being in the scientific literature, in Brazil there are few studies on the subject, especially population-based ones. Thus, this study aimed to investigate the quality of life and self-esteem in patients with intestinal stoma.

Methods

This is a clinical, primary, descriptive, analytical, prospective study.

This study was conducted at the Ostomized People's Pole at Pouso Alegre. Data were collected in the period between December 2012 and May 2013, after approval by the Research Ethics Committee from the *Universidade do Vale do Sapucaí* under Opinion No. 23,277. The sample was selected in a non-probabilistic way and by convenience. Data collection was conducted by the researchers themselves; all patients signed a free and informed consent form. Inclusion criteria were: age $\geq$ 18 years and be user of an intestinal stoma. Exclusion criteria were: patients with syndromes of dementia and/or other conditions that prevented them from understanding and answering to the questionnaires.

Three instruments to data collection for the survey were used. First, a questionnaire on demographic data and the stoma; a second instrument was Rosenberg Self-Esteem

Scale/UNIFESP-EPM; and the third was Flanagan Quality of Life Scale.

The Rosenberg scale is an instrument used in several studies on self-esteem.[10-12] It is an unidimensional scale translated and adapted in Brazil by Dini et al.[13] to be used in their study, having been applied to a population of patients who underwent plastic surgery.[11–13] The Rosenberg scale is a Likert-type 4-point scale (1 = I fully agree 2 = I agree, 3 = I disagree, 4 = I strongly disagree), containing 10 items. Of this total, 5 items evaluate the individual's positive feelings about themselves (In general, I am satisfied with myself; I feel I have some good qualities; I am able to do things as well as most other people, provided they are taught to me; I feel that I am a person of worth, at least on a level equal to other people; I take a positive view of myself) and 5 assess negative feelings (At times I think I am no good at all; I don't feel satisfaction in the things that I have done; I feel that I have not much to be proud of; sometimes I really feel myself useless, incapable of doing things; I wish I could have more respect for myself; Almost always I'm inclined to think I'm a loser). To score the responses, the five items that express positive feelings have their values inverted, which, added to the other five, add up to a single value for the scale. This scale consists of ten statements with four possible options for response. Each alternative has a value ranging from zero to three. Thus, it presents a final score of zero to 30, where zero is the best value for self-esteem and 30 the worst one.

The FQLS[14] conceptualizes the quality of life based on five dimensions: physical and material well-being, relationship with others, social, community and civic activities, personal development and fulfillment, and recreation. These dimensions are measured by 15 items, where the respondent has seven response options ranging from "very dissatisfied" (score 1) to "very satisfied" (score 7). 105 points is maximum score achieved in the assessment of quality of life proposed by Flanagan,[14] with 15 points being the minimum score, reflecting a low quality of life. It is worth noting that the scale is self-administered; however, some older people involved in this study received help from researchers in their answers to the instrument, because of physical limitations such as hand tremor, decreased visual and hearing acuity and low educational level.

The FQLS was developed for the United States and has not been validated for the Brazilian culture; However, Hashimoto et al. held its translation into Portuguese and applied FQLS for ostomized patients.[15,16] In 1998, Gonçalves et al. applied the scale in a relatively large and heterogeneous random sample and found high reliability for this instrument. Then, these authors used the same scale in a study involving elderly people,[15,16] verifying a good level of reliability – a factor that contributed to the decision to use this instrument in the present study.

In the statistical analysis, the following tests were used: the chi-squared test on demographic variables and on the "related to ostomy" variable, to determine if the distribution was proportional, that is, if the same number of subjects was allocated to each variable category. Kruskal–Wallis test and Spearman correlation were also used. For all statistical tests, significance levels of 5% ($p < 0.05$) were considered.

Results

In Table 1, it can be verified that the majority of participants were above 60 years old, male gender, retired, earned 1–3 minimum wages per month and attended support groups. Twenty-one (30%) of respondents were illiterate and 19 (25.10%) could read and write.

Table 2 shows that neoplasia was the most frequent cause for ostomy; permanent colostomy was the type of ostomy used. Most of the subjects were not told that they would receive a stoma. In addition, all subjects were not submitted to stoma demarcation and did not make irrigation. Regarding the type of complication, 34 (48.60%) had dermatitis; 14 (20%), retraction and 13 (18.60%), prolapse. With respect to the diameter of the stoma, 34 (48.60%) measured 20–40 mm and 23 (32.90%), 40–60 mm.

From Table 3, the participants' responses reveal that the mean score of Rosenberg Self-Esteem Scale/UNIFESP-EPM was 10.81 and the mean score of FQLS was 26.16, meaning that these ostomized patients had negative feelings related to self-esteem and showed a decreased quality of life.

According to Table 4, it was observed that most of participants got scores between 1 and 15 points in the Self-Esteem Scale, and between 16 and 22 points in FQLS, revealing that these patients showed quality of life and self-esteem changes.

Table 5 shows that the participants' responses reached 60 points (85.70%) for the question about independence (being able to do things for yourself) and 62 points (88, 61%) for questions about the job or work at home and participation in recreational and sports activities. Such values characterize changes in these aspects.

According to Table 6, a mean of 1.41–2.0 for all 16 items was obtained. These findings reflect a low degree of satisfaction, that is, the ostomized individuals in this study were dissatisfied with their lives.

Discussion

With regard to sociodemographic characteristics of our 70 patients with intestinal stoma, most were elderly, over 60 years, were male, retired, earned 1–3 minimum wages per month and attended support groups. Twenty-one patients (30%) were illiterate and 19 (25.10%) could read and write, which is in line with other studies on intestinal stoma users.[15–20]

The data relating to stoma indicated that, for most participants, neoplasia was the cause that led to stoma creation; and permanent ostomy was the type of ostomy used. Most of the subjects were not told that they would receive the stoma. Also, they were not submitted to stoma demarcation nor to irrigation. Regarding the type of complication, 34 (48.60%) had dermatitis; 14 (20%) retraction; and 13 (18.60%), prolapse. As the diameter of the stoma, 34 (48.60%) measured 20–40 mm and 23 (32.90%), 40–60 mm. These findings agree with several published studies.[15,19–25]

The increase in life expectancy, the industrialization process, the globalization and the effects of urbanization implied that the Brazilian population was exposed to more health problems, among which stands out cancer, trauma and

Table 1 – Sociodemographic characteristics of individuals with intestinal stoma.

Variable	*p*	*n*	% General	% Valid	% Pooled
Age group					
44–59 years		17	24.3	24.3	24.3
60–67 years		18	25.7	25.7	50.0
68–74 years	0.057	16	22.9	22.9	72.9
75–85 years		19	27.1	27.1	100.0
Total		70	100.0	100.0	
Marital status					
Married		34	48.6	48.6	48.6
Separated	0.035	14	20.0	20.0	68.6
Widow(er)		22	31.4	31.4	100.0
Total		70	100.0	100.0	
Schooling					
Illiterate		21	30.0	30.4	30.4
Can read and write		19	27.1	27.5	58.0
Elementary school Incomplete		11	15.7	15.9	73.9
High school, incomplete		2	2.9	2.9	76.8
High school, complete	0.007	4	5.7	5.8	82.6
Higher education, incomplete		3	4.3	4.3	87.0
Higher education, complete		9	12.9	13.0	100.0
Total		69	98.6	100.0	
Did not reply		1	1.4		
Total		70	100.0		
Occupation					
Retired		50	71.4	73.5	73.5
Unemployed		4	5.7	5.9	79.4
Working	0.003	14	20.0	20.6	100.0
Total		68	97.1	100.0	
Did not reply		2	2.9		
Total		70	100.0		
Support/association group					
Yes		38	54.3	54.3	54.3
No	0.075	32	45.7	45.7	100.0
Total		70	100.0	100.0	
Family income					
<1 Minimum wage		16	22.9	22.9	22.9
1–3 Minimum wages		36	51.4	51.4	74.3
3–4 Minimum wages	0.091	10	14.3	14.3	88.6
>5 Minimum wages		8	11.4	11.4	100.0
Total		70	100.0	100.0	

degenerative (and not degenerative) chronic diseases. Often these conditions may imply the use of an ostomy; and this requires professionals knowledgeable of innovative technological resources and in a position to promote autonomy for self-care and daily activities for their patients, with the aim to provide a better quality of life and well-being.[26]

When a patient receives a stoma, he/she begins to face many changes in his/her daily live that occur not only on the physiological level, but also on psychological, emotional and social levels. This has its consequences: suffering, pain, deterioration, uncertainty about the future and fear of rejection.[27]

The adaptation process occurs with the adjustment of a lifetime in a new context, in which important factors often must be abandoned, replaced or diminished. Therefore, this is an individual process that takes place over time, involving a number of aspects ranging from the assistance given, to how the ostomized person engages in self-care.[28]

In addition to the psychological, emotional and social problems already reported earlier, ostomized people face other setbacks, such as the exposure to a range of social constraints, the possibility of outgassing and excrement leakage due to the lack of voluntary control and also by flaws in the safety and quality of the collection bag, besides other complications. All in all, this triggers the fear of public exposure. Typically, such problems can be understood from the physical, psychological, social and spiritual dimensions.[29]

In this study, considering FQLS, the total score was between 16 and 26 points and the mean was 26.16, meaning that these patients demonstrated a decrease in their quality of life.

After surgery for the creation of a stoma, the patient experiences many negative feelings resulting from physiological, psycho-emotional and socio-cultural changes that permeate his/her life, provoking, in a greater or lesser extent, effects that may impact on its quality of life.

In a study that was developed with the aim of knowing the meanings attributed to the experience of ostomized patients, data were obtained through interviews and subjected to a content analysis. It was concluded that the ostomy signifies

Table 2 – Intestinal stoma characteristics.

	p	n	% General	% Valid	% Pooled
Gender					
Male	0.003	18	25.7	25.7	25.7
Female		52	74.3	74.3	100.0
Total		70	100.0	100.0	
Variable cause of ostomy					
Dificolite		3	4.3	4.3	4.3
Inflammatory bowel disease		5	7.1	7.1	11.4
Neoplasia	0.003	52	74.3	74.3	85.7
Crohn's disease		10	14.3	14.3	100.0
Total		70	100.0	100.0	
Variable type of estoma					
Colostomy		54	77.1	77.1	77.1
Ileostomy	0.007	16	22.9	22.9	100.0
Total		70	100.0	100.0	
Variable Stoma diameter					
0–20 mm		10	14.3	14.3	14.3
20–40 mm		34	48.6	48.6	62.9
40–60 mm	0.056	23	32.9	32.9	95.7
60–80 mm		3	4.3	4.3	100.0
Total		70	100.0	100.0	
Variable type of complication					
Dermatitis		34	48.6	48.6	48.6
Fistulae		1	1.4	1.4	50.0
Peristomal herniation		5	7.1	7.1	57.1
Pseudo-verrucous lesions		1	1.4	1.4	58.6
Allergic reaction to device	0.0023	1	1.4	1.4	60.0
Pseudo-verrucous lesions/Dermatitis		1	1.4	1.4	61.4
Retraction		14	20.0	20.0	81.4
Prolapse		13	18.6	18.6	100.0
Total		70	100.0	100.0	
Variable demarcation was performed?					
Yes		17	24.3	24.3	24.3
No	0.002	53	75.7	75.7	100.0
Total		70	100.0	100.0	
Variable type of device					
Single-system		22	31.4	31.4	31.4
Two pieces	0.043	48	68.6	68.6	100.0
Total		70	100.0	100.0	
Variable irrigation?					
Yes		26	37.1	37.1	37.1
No	0.047	44	62.9	62.9	100.0
Total		70	100.0	100.0	
Variable it was told that you would have to use a stoma?					
Yes		48	68.6	68.6	68.6
No	0.049	22	31.4	31.4	100.0
Total		70	100.0	100.0	
Variable stoma character					
Temporary		18	25.7	25.7	25.7
Permanent	0.003	52	74.3	74.3	100.0
Total		70	100.0	100.0	

a change in lifestyle; and that the nursing care, through educational activities, is indispensable to the development of self-care and for the adaptation of ostomized people, with consequent improvement in their quality of life.[28]

When receiving an intestinal stoma, beyond the stigma from society, these patients suffer the embarrassment of an arduous acceptance of the changes resulting from a continuously adaptive process. Self-care is a process inserted in the acceptance phase of their new physical and physiological condition, which should be seen as a necessary therapeutic treatment that aims to improve the pathological, psychological, emotional and social domains, in order to cure these patients, considering that the purpose is not to diminish the reduction in quality of life, self-esteem, self-image and

Table 3 – Results obtained in Rosenberg Self-Esteem Scale/UNIFESP-EPM and Flanagan Quality of Life Scale (FQLS) mean scores in individuals with intestinal stoma.

	Rosenberg Self-Esteem Scale/ UNIFESP-EPM	Flanagan Quality of Life Scale – FQVS	*p*
Mean	10.81	26.16	0.001
Median	11.00	19.00	
Mode	11	19	
Standard-deviation	5.395	19.897	

Table 4 – Results in Rosenberg Self-Esteem Scale/UNIFESP-EPM and Flanagan Quality of Life Scale (FQLS) total scores in individuals with intestinal stoma.

Total score	*p*	Rosenberg Self-Esteem Scale/UNIFESP–EPM			
		n	% General	% Valid	% Pooled
1		1	1.4	1.4	1.4
2		1	1.4	1.4	2.9
3		4	5.7	5.7	8.6
4		1	1.4	1.4	10.0
5		4	5.7	5.7	15.7
6		8	11.4	11.4	27.1
7		2	2.9	2.9	30.0
8		3	4.3	4.3	34.3
9		1	1.4	1.4	35.7
10		2	2.9	2.9	38.6
11	0.079	11	15.7	15.7	54.3
12		9	12.9	12.9	67.1
13		5	7.1	7.1	74.3
14		5	7.1	7.1	81.4
15		6	8.6	8.6	90.0
16		1	1.4	1.4	91.4
17		3	4.3	4.3	95.7
25		1	1.4	1.4	97.1
27		1	1.4	1.4	98.6
30		1	1.4	1.4	100.0
Total		70	100.0	100.0	

Total score	*p*	Flanagan Quality of Life Scale (FQLS)			
		n	% General	% Valid	% Pooled
16		10	14.3	14.3	14.3
17		6	8.6	8.6	22.9
18		1	1.4	1.4	24.3
19		29	41.4	41.4	65.7
20		5	7.1	7.1	72.9
21		2	2.9	2.9	75.7
22		6	8.6	8.6	84.3
31	0.037	1	1.4	1.4	85.7
37		2	2.9	2.9	88.6
55		2	2.9	2.9	91.4
59		1	1.4	1.4	92.9
84		1	1.4	1.4	94.3
85		2	2.9	2.9	97.1
99		2	2.9	2.9	100.0
Total		70	100.0	100.0	

sexuality of those who received the stoma, but to prioritize their health in all areas.[30] These patients feel shame and embarrassment, feelings that can get them to isolate themselves and to a life full of anxiety – maybe with a negative impact on their quality of life, self-esteem and body image.[31]

In a study whose authors identified those factors that interfered and changed the daily lives of ostomized individuals, it was concluded by the analysis of their reports that, among the factors identified, changes in everyday life and interpersonal relations (especially partner/partner relationship) were included, depriving the individual of a good quality of life, an adequate self-esteem, a positive body image and of his/her sexual life, that should be preserved and not stigmatized in society.[30] Another study in which the authors assessed the relationship between age and quality of life, it was concluded that older patients, on average, had higher scores for quality of life (65.21 against 61.87; the maximum score was 100, $p = 0.56$).[32]

In our study, after analyzing the responses of ostomized patients, the mean of Rosenberg Self-Esteem Scale/UNIFESP-EPM was 10.81. Such finding has characterized these patients as having low self-esteem.

Self-esteem means psychological well-being, that is, the patient feels satisfied with his/her life and the affections related to his/her body are positive, in that the emotional responses are stable over a period of time, reflecting acceptance of his/her self-image, as well as in the adaptation of processes arising from his/her life cycle and social relationships.[33–35]

In the process of adaptation, the patient with an intestinal stoma requires supports which are defined as interpersonal transformations, involving the combination of affection, social integration, exchange of mutuality, a secure sense of alliance and the meaning of guidance attainment.[36] When receiving this support, the patient succeeds in his/her self-care, which, in turn, has an effect on quality of life and self-esteem.

From the time the individual receives the stoma, he/she starts to experience feelings of helplessness due to the discomfort, embarrassment and shame of his/her body, especially the feeling of being dirty and repugnant,[37] leading to social isolation, change in body image and loss in his/her sexual life.

Low self-esteem can lead the patient to social isolation, which is visible in these individuals. However, it is important to stress that, given this reality, it is imperative the necessity for social interaction, as this process will contribute to the restoration of his/her perception of the body and self-image, mainly contributing to overcome the loneliness.[38]

In a study where the perception of patients with colostomy was analyzed regarding the use of the collector bag, it was possible to reveal the feelings and changes that have occurred; and how the adaptative process of the individual bearing a colostomy bag develops.

It was found that the relationship between the person with a colostomy and his/her collector bag is permeated by negative feelings and major changes in physical, psychological and sexual features, as well as in the web of his/her social relationships, resulting in low self-esteem.[26]

The sexual difficulties reported by some studies stem from the psychological state of the patient, the shame in face of the partner and from the feeling of being dirty and repugnant, that causes the fear of being rejected by others. This is because

Table 5 – Descriptive statistics: responses of participants to items of Flanagan Quality of Life Scale (FQLS) in individuals with intestinal stoma.

Questions of the scale	Scoring															
	1		2		3		4		5		6		7		Total	
	N	%	n	%	N	%	n	%	n	%	n	%	n	%	n	%
Q1	31	44.3	33	47.1	0	0.0	0	0.0	4	5.7	2	2.9	0	0.0	70	100.0
Q2	47	67.1	15	21.4	0	0.0	3	4.3	0	0.0	5	7.1	0	0.0	70	100.0
Q3	50	71.4	10	14.3	2	2.9	2	2.9	1	1.4	0	0.0	5	7.1	70	100.0
Q4	28	40.0	34	48.6	2	2.9	1	1.4	0	0.0	1	1.4	4	5.7	70	100.0
Q5	32	45.7	28	40.0	2	2.9	3	4.3	2	2.9	1	1.4	2	2.9	70	100.0
Q6	51	72.9	8	11.4	3	4.3	1	1.4	2	2.9	3	4.3	2	2.9	70	100.0
Q7	49	70.0	13	18.6	2	2.9	1	1.4	0	0.0	2	2.9	3	4.3	70	100.0
Q8	55	78.6	10	14.3	1	1.4	0	0.0	0	0.0	2	2.9	2	2.9	70	100.0
Q9	55	78.6	9	12.9	1	1.4	2	2.9	1	1.4	0	0.0	2	2.9	70	100.0
Q10	51	72.9	11	15.7	1	1.4	2	2.9	1	1.4	2	2.9	2	2.9	70	100.0
Q11	62	88.6	0	0.0	1	1.4	3	4.3	0	0.0	2	2.9	2	2.9	70	100.0
Q12	54	77.1	8	11.4	3	4.3	0	0.0	0	0.0	3	4.3	2	2.9	70	100.0
Q13	62	88.6	2	2.9	0	0.0	1	1.4	1	1.4	4	5.7	0	0.0	70	100.0
Q14	58	82.9	4	5.7	1	1.4	2	2.9	0	0.0	4	5.7	1	1.4	70	100.0
Q15	57	81.4	4	5.7	1	1.4	0	0.0	2	2.9	6	8.6	0	0.0	70	100.0

Q1, Material comfort: housing, food, financial situation; Q2, Health: to feel physically well and with energy; Q3, Relationship with relatives, social coexistence, communication, helping; Q4, Family constitution: having and raising children; Q5, Intimate relationship with spouse or partner; Q6, Relationship with friends; Q7, Helping and supporting others; Q8, Participation in public interest associations and activities; Q9, Apprenticeship: having the opportunity to increase your general knowledge; Q10, Self-knowledge: knowledge about your potentials and limitations, to know what you want, important goals for your life; Q11, Occupation at work or at home; Q12, Knows how to communicate; Q13 Participation in recreational and sports activities; Q14, Listening to music, Watching TV or movies, reading and other entertainments; Q15, Socialization: make friends. Independence: feel able to do things for yourself.

Table 6 – Results obtained in Flanagan Quality of Life Scale (FQLS) mean score in individuals with intestinal stoma.

Items of scale	Scoring			
	n	Mean	Median	Standard-deviation
Q1	70	1.84	2.0	1.187
Q2	70	1.70	1.0	1.387
Q3	70	1.77	1.0	1.661
Q4	70	2.00	2.0	1.474
Q5	70	1.94	2.0	1.371
Q6	70	1.74	1.0	1.567
Q7	70	1.69	1.0	1.499
Q8	70	1.49	1.0	1.316
Q9	70	1.47	1.0	1.224
Q10	70	1.64	1.0	1.435
Q11	70	1.47	1.0	1.411
Q12	70	1.59	1.0	1.440
Q13	70	1.41	1.0	1.291
Q14	70	1.54	1.0	1.431
Q15	70	1.63	1.0	1.534

Q1, Material comfort: housing, food, financial situation; Q2, Health: to feel physically well and with energy; Q3, Relationship with relatives, social coexistence, communication, helping; Q4, Family constitution: having and raising children; Q5, Intimate relationship with spouse or partner; Q6, Relationship with friends; Q7, Helping and supporting others; Q8, Participation in public interest associations and activities; Q9, Apprenticeship: having the opportunity to increase your general knowledge; Q10, Self-knowledge: knowledge about your potentials and limitations, to know what you want, important goals for your life; Q11, Occupation at work or at home; Q12, Knows how to communicate; Q13 Participation in recreational and sports activities; Q14, Listening to music, Watching TV or movies, reading and other entertainments; Q15, Socialization: make friends. Independence: feel able to do things for yourself.

all human beings construct, throughout their life, an image of their own body that has to do with the customs and the environment in which they live, in order to have their needs met and to be situated in their own world. Body image is linked to concepts of youth, beauty, vigor, integrity and health. Therefore, those who deviate from the concept of body beauty may experience feelings of rejection and exclusion.[39]

In a study that evaluated the impact of a stoma in people's lives, the authors concluded that when a person receives an intestinal stoma, several changes take place in the lifestyle of these individuals, involving the need for learning self-care or changes in relation to its lifestyle with respect to their social participation, as well as sexual implications. Anyway, the fear that the individual has about this unknown situation involves the development of an intimate and psychosocial discomfort.[40]

Thus, the person that received an ostomy should not understand the ostomization as a hindrance to his/her social and sexual life, but as a new condition needing adjustment. Given that the occurrence of any change is difficult, the professional who is providing care must go hand in hand with his/her patient, so that in this way the patient feels supported and willing to seek help.[41]

This study reinforces the need to redirect our attention to the health of patients with intestinal stoma, seeking to identify, in the day-to-day practice of health services, in poles of ostomy care, hospitals or outpatient clinics and in Family Health Programs, the presence of changes in quality of life, self-esteem, self-image, well-being and sexuality. It is important that the major needs in the care of ostomized patients in their daily lives are resolved; it is also essential that the caregiver has sufficient knowledge to deal with the disabilities of these patients.

Considering the needs that emerged in recent decades with the increasing number of patients with chronic diseases that can lead an individual to live with an intestinal stoma, it is essential to redirect our academic training and the qualification of our health professionals, emphasizing not only the content, but also the practice of care offered to these people. And it is also critical that these professionals become aware of the importance of ostomized people performing self-care.

Conclusion

Patients in this study showed low self-esteem and quality of life.

Conflicts of interest

The authors declare no conflicts of interest.

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