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UAE STOMA
SUPPORT CLUB
by EMIRATES SOCIETY OF COLON & RECTAL SURGERY

UAE NATIONAL GUIDELINE OF STOMA CARE



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PREFACE

The UAE National Stoma Care Guidelines provide a unified, evidence-based framework for the care of individuals living with a stoma across the United Arab Emirates. They aim to standardize clinical practice and promote safe, high-quality, patient-centered care throughout the stoma pathway.

Developed through multidisciplinary expert collaboration and review of current evidence, the guidelines reflect international best practices while addressing the healthcare context, resources, and needs of patients in the UAE.

By establishing national standards for stoma care, these guidelines seek to improve care coordination, reduce variation in practice, prevent and manage complications, and enhance patient outcomes and quality of life. They will be regularly reviewed and updated in line with evolving evidence and clinical practice.

This document is intended as a clinical practice reference. It does not replace individualized clinical judgment, institutional policy, or the guidance of a qualified religious authority.

Editor- in -Chief

September 2026

CONTENTS

1 PURPOSE AND SCOPE 5
2 HOW TO USE THIS DOCUMENT 5
3 POUCHING SYSTEM SELECTION AND WEAR TIME 6
4 PREOPERATIVE STOMA SITE MARKING 6
5 SELECTION OF OSTOMY PRODUCTS AND SUPPORTING ACCESSORIES 7
6 THE ROLE OF ENTEROSTOMAL THERAPY NURSES AND SPECIALIST OSTOMY SERVICE 7
7 COMPLICATED STOMAS — RECOGNITION AND REFERRAL PATHWAYS 7
8 PATIENT AND CAREGIVER EDUCATION 9
9 PSYCHOSOCIAL WELLBEING AND QUALITY OF LIFE 10
10 RELIGIOUS AND SPIRITUAL CONSIDERATIONS FOR MUSLIM PATIENTS 10
11 UNMET NEEDS AND RECOMMENDATIONS FOR THE UAE HEALTH SYSTEM 11
12 SUMMARY TABLE — SUGGESTED POUCHING CHANGE FREQUENCY 12
REFERENCES 13
APPENDIX A — TEXT OF THE FATWA RULING 14
APPENDIX B — TEXT OF THE SHARJAH FATWA RULING (SUPPORTING OPINION) 15

SECTION 1 — PURPOSE AND SCOPE

This document sets out practical, consensus-oriented recommendations for the care of patients living with stoma in the United Arab Emirates. It is written for enterostomal therapy nurses (ETNs), colorectal and general surgeons, and other allied healthcare professionals involved in the preoperative, perioperative, and long-term management of ostomy patients.

Colorectal cancer remains the leading indication for ostomy formation in the UAE, alongside inflammatory bowel disease, complex perianal sepsis, and diversion after emergency bowel surgery. As colonoscopy screening programmes expand and survivorship improves, the number of patients living with a stoma in the UAE is expected to continue rising, making consistent, high-quality stoma care an increasing priority for the health system.

A feature of this framework, distinguishing it from general international ostomy guidance, is a dedicated section addressing the religious and spiritual dimension of stoma care for Muslim patients — an area that is insufficiently addressed in clinical training despite its direct bearing on treatment acceptance and quality of life. This section is anchored in an official national fatwa issued by the UAE Council for Fatwa at the direct request of the Emirates Society of Colon & Rectal Surgery (ESCRS), supported by an earlier opinion from the Government of Sharjah Permanent Fatwa Committee, specifically addressing prayer for patients carrying a medical waste-collection pouch.

1.1 How this guidance is graded

This framework is best characterized as consensus-based expert clinical guidance rather than a formally graded evidence-based guideline. Individual recommendations have not been formally graded using GRADE or an equivalent framework. Where evidence is strong and consistent, this is stated explicitly; where international guidance differs, the competing positions are presented transparently rather than selectively omitted. Adoption of formal GRADE rating is recommended for a future edition.

To help readers distinguish the basis for individual statements, this edition tags a representative selection of key recommendations with one of four descriptive labels:

- [Evidence-based] recommendations supported by clinical trial or systematic-review evidence.
- [Consensus] practices reflecting expert or professional-society agreement where high-quality comparative evidence is limited.
- [UAE health-system] recommendations addressing local service organization, access, or infrastructure rather than clinical technique.
- [Religious guidance] content drawn from the ruling summarized in Section 10 and reproduced in Appendix A.

These labels are descriptive rather than a formal GRADE rating and are not applied exhaustively to every sentence.

Scope exclusion: Pediatric stoma care and continent urinary diversions (e.g., Indiana pouch, orthotopic neobladder) fall outside its scope.

Governance: prepared under the auspices of authoring committee with input from enterostomal therapy nursing, colorectal surgery, and relevant specialist reviewers. Scheduled for formal review on a 3-year cycle, with the next review due in 2029 or sooner should significant new evidence emerge.

SECTION 2 — HOW TO USE THIS DOCUMENT

The recommendations below are organized by clinical theme: pouching system selection and wear time, preoperative site marking, product selection, the role of specialist nursing, patient education, psychosocial wellbeing, and — specific to this framework — religious accommodation. Clinical judgment and individual patient circumstances should always take precedence over generic recommendations.

SECTION 3 — POUCHING SYSTEM SELECTION AND WEAR TIME

Selecting a pouching system is central to preventing leakage, protecting skin, and supporting a predictable routine for the patient. The type of stoma (colostomy versus ileostomy) should guide the initial choice of system:

- Colostomy patients are well served by a closed pouch system, though this applies more to a distal colostomy with formed output. A one-piece pouch is typically changed once effluent reaches roughly two-thirds capacity (commonly once daily). In a two-piece system, the baseplate is usually changed two to three times weekly with the pouch changed as needed. A transverse colostomy produces looser, higher-volume output and is often managed with a drainable pouch system, similar in principle to an ileostomy, rather than a closed pouch [2,6].
- Ileostomy patients, who produce a more liquid, continuous output, are better served by a drainable pouch system, emptied several times daily and with the pouch or baseplate changed two to three times weekly [2,6].
- These suggested intervals serve as a general guide and should be tailored to stoma characteristics, skin integrity, environmental factors, and patient preference.
- Diet has a significant influence on stoma output consistency and volume, particularly in ileostomy patients during the early postoperative period; patients should be counselled on the effects of specific foods, the value of introducing new foods sequentially to identify individual triggers, and the importance of adequate fluid and sodium intake as output stabilizes. [1].

Wear time is influenced by multiple factors, including stoma height and diameter, whether the stoma is flush or retracted, time since stoma formation, peristomal skin folds or scarring, local climate (with hot and humid conditions tending to shorten wear time), and the appropriate use of adjunct products such as barrier rings, paste, or support belts. Patients with a higher body mass index or pronounced peristomal skin folds often require more frequent changes and benefit from convex baseplates or mouldable rings to maintain a secure seal [6].

Peristomal skin should be assessed using a validated tool. The Ostomy Skin Tool (AIM) and the WOCN Society's Peristomal Skin Assessment Guide are available validated instruments. Assessment should also take cultural, ethnic, and skin-tone factors into account, since these influence how peristomal skin changes present — a relevant consideration given the UAE's ethnically diverse patient population [2].

SECTION 4 — PREOPERATIVE STOMA SITE MARKING

[**Evidence-based**] Preoperative site marking by a trained ETN, or, where one is not available, by a suitably trained surgeon or nurse, is a mandatory requirement for all elective ostomy procedures. Evidence consistently associates preoperative marking with fewer early and late stoma complications, better pouching system fit, and improved patient quality of life, compared with unmarked stomas.

For emergency procedures where preoperative marking is not feasible, institutions should follow a defined escalation protocol: the operating surgeon selects the best achievable site intraoperatively guided by general marking principles (avoiding skin folds, scars, the umbilicus, and the belt line where possible), this deviation is documented in the operative note, and the ETN team reviews the patient at the earliest opportunity in the postoperative period [5].

The proposed site is ideally assessed with the patient standing, sitting, and supine, since abdominal contour and skin folds can change between positions. The chosen site should also be visible and accessible to the patient for independent self-care, and should avoid significant skin folds, scars, bony prominences, and the belt line where possible. Marking should take into account the patient's body habitus, skin folds, scars, belt line, and lifestyle (occupation, mobility, and clothing preferences). The purpose and procedure of stoma marking should be explained to the patient, after which consent must be obtained and documented.

SECTION 5 — SELECTION OF OSTOMY PRODUCTS AND SUPPORTING ACCESSORIES

Stoma appliance selection should be individualized, as no single product is suitable for all patients and requirements may change as the stoma matures. The baseplate opening is tailored close to the stoma using a measuring guide to prevent leakage and protect peristomal skin. Baseplates are available as flat, convex, or concave designs, with convex baseplates particularly useful for retracted or flush stomas and concave designs for patients with abdominal curves or bulges.

A transparent pouch is preferred in the immediate postoperative period to ease visual monitoring of stoma viability and output, with a transition to an opaque pouch after discharge for discretion and comfort. Supporting products — skin barrier powders and wipes, adhesive removers, barrier rings, paste, elastic tape, and support belts — should be used according to individual skin condition and sealing need rather than applied routinely. Product selection should be informed by a validated peristomal skin assessment (see Section 3) rather than by visual impression alone [2].

SECTION 6 — THE ROLE OF ENTEROSTOMAL THERAPY NURSES AND SPECIALIST OSTOMY SERVICES

Enterostomal therapy nurses play a vital role in delivering safe, consistent ostomy care across the patient pathway, including preoperative counselling and stoma site marking, inpatient education, and long-term outpatient follow-up. The establishment of dedicated ostomy clinics with multidisciplinary input, including nursing, surgery, dietetics, psychology, and social work is recommended. Such models of care are associated with reduced complication rates, fewer unplanned readmissions, and improved patient-reported outcomes.

In view of the limited availability of formally accredited stoma-care training pathways within the region, healthcare institutions in the UAE are encouraged to support nurses in obtaining recognized international ostomy nursing certification, such as WCET or WOCNCB certification. This should be complemented by structured local mentorship programs to help address current training gaps.

6.1 Early postoperative follow-up

Early review by an enterostomal therapy nurse (ETN) after discharge is recommended for all patients with a new ostomy, and is particularly important for patients with a new ileostomy, as stoma size, peristomal contour, and appliance requirements frequently change during the early postoperative period. Where local resources allow, an initial outpatient ETN review within 1–2 weeks of discharge, followed by a further review at approximately 4–6 weeks, is recommended to identify appliance fit and peristomal skin issues at an early stage. Earlier review should be arranged if leakage, skin breakdown, or other concerns as outlined in Section 8.4.

SECTION 7 — COMPLICATED STOMAS: RECOGNITION AND REFERRAL PATHWAYS

Most stoma-related problems can be managed by an enterostomal therapy nurse (ETN) or the general clinical team using standard measures. However, a subset of patients will develop complications that require timely specialist or surgical review. To support consistent and safe decision-making, the table below integrates clinical presentation, urgency of review, and appropriate referral destination into a single triage reference.

7.1 Triage framework for stoma-related complica7ons

Presentation	Urgency	Refer to
Suspected ischemia/necrosis; irreducible or strangulated prolapse or hernia; signs of obstruction; high output with hemodynamic compromise or AKI	Emergency — same day	On-call general/colorectal surgical team
Reducible but symptomatic parastomal hernia; non-strangulated prolapse; worsening stenosis/retraction; persistent moderate-high output without compromise; skin breakdown failing initial ETN treatment; mucocutaneous separation, fistula, or peristomal pyoderma gangrenosum	Urgent — days	Specialist ETN or colorectal outpatient clinic
Stable but symptomatic hernia/prolapse for elective revision; reassessment of pouching strategy after repeated product failures	Routine — weeks	Dedicated complex stoma / parastomal hernia clinic

7.2 Key Clinical principles

Ischemia - Assessment of ischemia should focus on depth rather than surface appearance.

Superficial mucosal discoloration confined above the fascial level may be managed with close observation, whereas ischemia extending below the fascial plane with full-thickness (transmural) necrosis requires urgent surgical exploration. Where ischemia is suspected, assessment of mucosal viability at depth using a bedside test-tube technique or endoscopy is recommended, rather than reliance on surface appearance alone [6].

High-output stoma- Management should be guided by physiological impact rather than volume alone.

Electrolytes and renal function should be assessed once ileostomy output exceeds 1,200 mL/day, with 1,500 mL/day used as the threshold for active intervention. Management should include anti-motility agents such as loperamide and/or codeine phosphate, use of oral rehydration solutions in preference to hypotonic fluids to address sodium loss, and close ongoing monitoring of renal function and electrolytes [14].

Service planning and escalation pathways

In settings where a dedicated complex stoma or parastomal hernia service is not available, institutions should identify and formally document a named regional or tertiary referral pathway in advance. Local protocols should also clearly specify out-of-hours escalation arrangements for urgent surgical concerns. Delayed recognition or referral of complications, including ischemia or strangulated hernia, is associated with significantly worse clinical outcomes.

7.3 Parastomal hernia prevention

Consideration of parastomal hernia prevention should occur at the time of stoma creation, rather than only after hernia development. Current international guidance is not uniform. The 2022 American Society of Colon and Rectal Surgeons (ASCRS) guideline does not recommend routine prophylactic mesh placement at stoma formation, whereas the 2023 European Hernia Society (EHS) guideline provides a conditional recommendation for prophylactic mesh in patients undergoing end colostomy with a reasonable life expectancy, and a strong recommendation in patients at increased risk. Highrisk factors include a history of abdominal wall hernia, connective tissue disorders, obesity, and planned chemotherapy. A 2023 joint EHS–ESCP–EAES metaanalysis of randomized controlled trials demonstrated that prophylactic synthetic mesh significantly reduced the incidence of parastomal hernia, although it did not significantly reduce the proportion of patients requiring surgical repair [4,13].

7.4 Stoma reversal and closure planning

Temporary stomas, particularly loop ileostomies constructed to protect a distal anastomosis, account for a substantial proportion of stomas created in colorectal practice. Planning for stoma reversal should therefore be undertaken at the time of stoma formation, rather than deferred until patientinitiated discussion. Loop ileostomy closure is generally recommended within 3 to 6 months of the index operation, subject to confirmation of anastomotic integrity per institutional protocol, completion or resolution of adjuvant treatment considerations, and adequate patient recovery [3].

Patients should be counselled preoperatively that the stoma is intended to be temporary, provided with an approximate timeframe for reversal, and given a clearly identified point of contact for reversal assessment and scheduling.

SECTION 8 — PATIENT AND CAREGIVER EDUCATION

Structured, timely patient and caregiver education is a core component of safe stoma care and is associated with improved self-management, reduced anxiety, fewer unplanned nurse visits, and lower rates of emergency presentations.

8.1 Preoperative education

Where clinical circumstances permit, preoperative education should be provided in clear, plain language, and should include the indication for stoma formation, an overview of the surgical procedure, the purpose of stoma site marking, and the appliances and supplies that would be required postoperatively. Patient should also be given a general outline of expected recovery trajectory, including anticipated short-term changes in diet, clothing, physical activity, and daily routines.

8.2 Postoperative and discharge education

Before discharge, patients and caregivers should receive structured, hands-on education covering pouch emptying and changing, recognition of early warning signs (including leakage, skin breakdown, unusual odor, or prolapse), dietary adjustments, and the psychosocial and body-image aspects of adapting to life with a stoma. Discharge should not rely on verbal instruction alone. The patient, or an identified caregiver where appropriate, must demonstrate independent competence in pouch, emptying and changing, with this competency documented in the discharge record.

Education should be reinforced using accessible, supplementary resources, including digital tools, such as patient applications and instructional videos, as well as written written materials available in multiple languages, reflecting the multilingual patient population within the UAE.

Given the prevalence of rectal cancer as an indication for storm of formation, and the recognized risk of sexual dysfunction, following low anterior section and abdominal perineal excision, postoperative counseling should extend beyond the general discussion of intimacy. Where dysfunction is anticipated or identified, the patient should be referred through a defined pathway to specialist sexual health services or pelvic floor physiotherapy [1].

8.3 Nutritional and dietary management

Dietary guidance should form a standard component of patient education and should not be limited to informal or ad hoc counseling. In the early postoperative period, patients with an ileostomy should be advised to introduce food gradually, chewed thoroughly, and cautiously reintroduce foods with an increased risk of bolus obstruction such as high-fiber, stringy, and skin-heavy foods. As output stabilizes, patients should be counselled on maintaining adequate sodium and fluid intake. Given that ileostomy output is sodium-rich, fluid replacement strategies should emphasize dietary sodium and oral rehydration solutions rather than unrestricted water intake or excessive fluid restriction for the management of loose output.

Patients with a colostomy progress more rapidly toward a normal diet, guided by individual tolerance. Referral to a dietitian is recommended for patients with persistent high output, unintended weight loss,

recurrent dehydration, and difficulty achieving adequate oral intake requiring parenteral or enteral nutritional support [1,14].

8.4 Discharge red-flag summary

All patients, or their caregivers, should be provided with a clear, plain-language summary of red flag symptoms at discharge, prompting urgent review through the pathways outlined in Section 7 if any of the following occur:

- A dusky, black, or otherwise abnormally discoloured stoma.
- Severe or worsening abdominal pain, distension, or vomiting, or no stoma output for longer than expected — possible signs of obstruction.
- Uncontrolled or heavy bleeding from the stoma.
- A prolapse that cannot be pushed back, or that becomes discoloured or painful.
- Signs of significant dehydration, or output that is persistently very high (see Section 7.1).
- Peristomal skin breakdown that is rapidly worsening despite standard care.

This list is intended to complement, rather than replace, the detailed guidance in Section 7 and should be printed on or attached to the discharge stoma care plan [1,2].

SECTION 9 — PSYCHOSOCIAL WELLBEING AND QUALITY OF LIFE

Ostomy formation affects multiple domains of a patient's life, including physical comfort, body image, family and social relationships, employment, and psychological wellbeing. Symptoms of anxiety and depression are common following ostomy surgery and should be identified proactively. Patients should be screened using a validated instrument, such as the Hospital Anxiety and Depression Scale (HADS) or the Patient Health Questionnaire9 (PHQ9), rather than relying on patients to raise concerns spontaneously. Screening is recommended prior to discharge and again at the first postoperative outpatient review. Access to culturally appropriate psychological support, peer or supportgroup engagement, and social work input should be considered integral components of routine ostomy care, rather than optional adjuncts [3].

Bodyimage concerns following ostomy surgery may have additional culturally specific dimensions within the UAE and wider Gulf context. These may include perceptions related to prayer and ritual purity, ablution, marital intimacy, and social stigma. Such issues should be explored proactively as part of structured psychosocial assessment, rather than deferred to patientinitiated discussion. Clinicians should be prepared to link concerns relating to religious practice to the guidance outlined in Section 10 and to facilitate support and counselling where required [7,9].

SECTION 1O — RELIGIOUS AND SPIRITUAL CONSIDERATIONS FOR MUSLIM PATIENTS

Because the majority of the UAE resident population is Muslim, questions relating to ritual purity and the validity of prayer are among the most frequently encountered, yet often insufficiently addressed, concerns raised by patients with an ostomy. International literature indicates that some Muslim patients reduce or discontinue prayer, avoid congregational or Friday prayer, or observe fasting contrary to medical advice following ostomy surgery. These behaviours are commonly driven by the mistaken belief that the presence of a stoma pouch permanently invalidates prayer. When left unaddressed, such beliefs may result in significant and avoidable spiritual distress, compounding the physical and psychological adjustment to life with a stoma [7,9].

To provide UAE clinicians with an authoritative, locally grounded reference on this point, this framework is anchored in Fatwa No. 14 of 2026 (Reference No. OUT/GMO/2026/113), issued on 1 September 2026 by the UAE Council for Fatwa — the Emirates' national religious authority — in direct response to a formal request submitted by ESCRS specifically to underpin this guideline. This national ruling supersedes, while broadly confirming, an earlier supporting opinion obtained from the Permanent Fatwa Committee of the

Government of Sharjah (Reference No. 025-18/2026, dated 15 July 2026), which had addressed the same question for colorectal cancer patients with a stoma pouch and for bladder cancer patients with a urinary collection pouch, and which is reproduced for reference in Appendix B.

10.1 Summary of the ruling

Where a colostomy or ileostomy lies below the stomach and becomes the sole exit for stool and gas, it is treated the same, for purity and prayer purposes, as the natural opening it replaces. A patient unable to control the timing of stool or gas passing from the stoma is considered to have a chronic incontinence: this does not invalidate wudu, and wudu is broken only by output the patient is able to control. Waste that leaves the body continuously and involuntarily is excused from the general purification requirement — there is no obligation to clean soiled skin or clothing, or to clean the pouch, before each prayer, and carrying it does not prevent attendance at Friday or congregational prayer, provided the pouch is securely closed so as to safeguard the cleanliness of the mosque and cause no harm to others; a patient unable to attend Friday prayer should instead pray Dhuhr as four rak'ahs. As long as wudu does not need to be renewed on account of stoma output, each prayer should in principle be performed at its own time; where this is a hardship, Dhuhr may be combined with Asr, and Maghrib with Isha, but only to the extent the need requires, and not as a standing habit. This dispensation lasts only as long as the pouch remains medically necessary: once a patient recovers and no longer needs it, the pouch must be removed and any soiled skin or clothing purified before prayer. Prayers correctly performed while the pouch was in use remain valid after recovery and do not need to be repeated [15].

10.2 Practical implications for the clinical team

Given the frequency with which religious concerns arise following ostomy formation, the clinical team should address these issues proactively as part of routine care.

- Patients should be reassured, ideally during preoperative counselling, that the presence of a stoma pouch does not in itself invalidate prayer, and that established scholarly guidance exists on this issue.
- Where stoma output cannot be controlled, this is treated as a form of chronic incontinence for ablution purposes: wudu is not broken by output the patient cannot control, and clinicians should reassure patients that a fresh ablution is only required in relation to output they could have controlled [15].
- Patients may continue to attend Friday and congregational prayer provided the pouch is securely sealed, poses no risk to the cleanliness of the mosque, and causes no harm to others; where attendance is not possible, the patient may instead pray Dhuhr as four rak'ahs [15].
- Where patients or family members request further clarification, clinicians should avoid personal interpretation or extension of religious rulings beyond the guidance presented. Patients with individual, complex, or unusual circumstances should be encouraged to seek advice directly from a recognized religious authority [8].
- Enterostomal therapy nurses (ETNs) and ward staff should be aware that, where feasible, patients may benefit from practical advice on timing pouch changes in relation to prayer, while making clear that precise timing is not a religious requirement.
- Discharge education materials should explicitly state that measures such as combining prayers or praying while seated or lying down are recognized accommodations for patients with ongoing medical hardship, and do not represent a deviation from religious observance. Combining prayers is a need-based allowance rather than a permanent practice, and should be used only to the extent the underlying hardship requires [15].
- Fasting during Ramadan constitutes a separate issue governed by specific religious rulings and the patient’s overall medical condition. Patients should be encouraged to seek tailored guidance rather than assuming that ostomy formation automatically permits or precludes fasting.
- Healthcare institutions should maintain a clearly identified referral pathway to a recognized national or local religious authority to support patients or families who require casespecific advice beyond this guideline.

SECTION 11 — UNMET NEEDS AND RECOMMENDATIONS FOR THE UAE HEALTH SYSTEM

Consistent with wider regional experience, gaps remain in the availability and affordability of ostomy supplies, equitable access to specialist ETN services outside major urban centers, and formal recognition of stomacare nursing as a distinct specialty by UAE regulatory bodies. Addressing these gaps through improved

supplychain planning, review of insurance coverage, and investment in accredited specialist training pathways would significantly enhance continuity and quality of care for ostomy patients in the UAE [11]. Patient feedback consistently highlights that the greatest unmet need for support occurs outside routine clinic hours. In the absence of timely access to advice, patients may present unnecessarily to emergency departments, attempt unsafe selfmanagement, or delay seeking care until the next working day.

[**UAE Heath-System**] The establishment of a dedicated, adequately resourced stoma support pathway is recommended as a national priority, with the following core components:

- A 24hour stoma support helpline, staffed or triaged by ETNs or appropriately trained nursing staff, with defined escalation pathways to oncall surgical teams when redflag symptoms are reported.
- A complementary digital platform or application providing selftriage guidance, troubleshooting resources, instructional videos, and options for secure messaging or callback.
- Provision of helpline and digitalplatform contact details to all patients at discharge, printed on the stoma care plan or supply prescription, and reinforced during preoperative and postoperative education.
- Where individual institutions lack sufficient case volume to support a standalone 24hour service, a shared or regional helpline pooling ETN resources across multiple centres is a suitable alternative, provided that escalation and referral back to the patient's primary surgical team are clearly defined.
- A structured escalation framework linked to symptom severity, with routine queries managed by ETN or trainednurse triage, unresolved or uncertain concerns escalated promptly to the oncall surgical team, and any redflag symptoms (Section 8.4) directed immediately to emergency department assessment without delay.

As an interim and standing resource for both patients and clinicians, further information and support is available via the ESCRS Stoma Resource Platform (stoma.escrs.ae).

SECTION 12 — SUMMARY TABLE — SUGGESTED POUCHING CHANGE FREQUENCY

Stoma Type	System	Component	Suggested Frequency
Colostomy	One-piece	Pouch	When ~2/3 full (≈ daily)
Colostomy	Two-piece	Baseplate / Pouch	Baseplate 2–3×/week; pouch ≈ daily
Ileostomy	One-piece	Drainable Pouch	Pouch emptied 4–8×/ day; baseplate/pouch changed 2–3×/week
Ileostomy	Two-piece	Baseplate / Drainable Pouch	Pouch emptied 4–8×/ day; baseplate/pouch changed 2–3×/week

Note: frequencies are a general starting point and should always be adjusted to individual stoma output, skin condition, and clinical judgment (see Section 3).

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15. UAE Council for Fatwa (Majlis al-Emarat lil-Ifta al-Shar'i). Fatwa No. 14 of 2026: ruling on the colostomy and the pouch affixed to the abdominal wall for waste containment. Reference No. OUT/GMO/2026/113. United Arab Emirates; issued 19 Rabi' al-Awwal 1448H (1 September 2026), in response to a request from the Emirates Society of Colon & Rectal Surgery (ESCRS). Signed by Dr. Sabea Salem Al Kaabi, Secretary General.

APPENDIX A — TEXT OF THE UAE COUNCIL FOR FATWA RULING (FATWA NO. 14/2026)

This appendix reproduces, as a plain-language rendering, the national ruling issued by the UAE Council for Fatwa (Fatwa No. 14 of 2026, Reference No. OUT/GMO/2026/113, dated 19 Rabi' al-Awwal 1448H / 1 September 2026), issued in direct response to a formal request from ESCRS to inform this guideline. This is the primary religious authority for the clinical team's practical interpretation in Section 10.2; a supporting opinion obtained earlier from the Government of Sharjah is reproduced in Appendix B. This is not an official translation; institutions or individuals requiring an authoritative version should request it directly from the Council [15].

[Religious guidance] The Council's ruling can be summarized, for clinical purposes, as follows:

- First: a colostomy or ileostomy located below the stomach that becomes the sole route by which stool and gas leave the body takes the same ruling, for purity and prayer purposes, as the natural point of exit it replaces.
- Second: a patient who is unable to control the timing of stool or gas passing through the stoma is considered to have a chronic incontinence, which does not affect the validity of wudu, whether the output passes through the natural exit or the alternative one. Wudu is broken, in this situation, only by output the patient is able to control.
- Third: waste that leaves the body continuously and without the patient's control is excused from the general requirement of purification, given the hardship a strict requirement would impose. There is no obligation to clean the body or clothing of what it soils, nor to clean the pouch fixed to the abdominal wall before standing for prayer; carrying it does not prevent the patient from attending Friday or congregational prayer, provided it is securely closed in a way that safeguards the cleanliness of the mosque and causes no harm to others. A patient unable to attend Friday prayer should instead pray Dhuhr as four rak'ahs.
- Fourth: as long as the patient does not need to renew their wudu on account of stool or gas passing from the colostomy, the default is to perform each prayer at its own time. Where this is a hardship, or there is a genuine need to combine prayers, the patient may combine Dhuhr with Asr and Maghrib with Isha, whether combined early or late — but only to the extent the need requires, and not as a permanent habit; the allowance is measured against the need and lapses once the need passes.
- Fifth: the exemption from purifying what passes from the body continues for as long as the patient needs the pouch fixed to the abdominal wall. Once the patient recovers and no longer needs it, the exemption lapses, and the pouch must be removed and anything it soiled on the body or clothing purified before prayer, since the cause that justified the exemption from impurity has ended.
- Sixth: if the patient recovers and no longer needs the colostomy, the prayers they performed during the period the pouch was fixed to the abdominal wall are valid, and they are not required to repeat them.

The Council closed its ruling with the standard formula acknowledging that God knows best. It was issued on 19 Rabi' al-Awwal 1448H (1 September 2026), addressed to Dr. Sara Al Bastaki, President of ESCRS, in response to ESCRS's letter of 6 Rabi' al-Awwal 1448H (19 August 2026), and signed by Dr. Sabea Salem Al Kaabi, Secretary General of the UAE Council for Fatwa [15].

APPENDIX B — TEXT OF THE SHARJAH FATWA RULING (SUPPORTING OPINION)

This appendix reproduces the earlier, supporting ruling issued by the Permanent Fatwa Committee of the Government of Sharjah (Reference No. 025-18/2026, dated 15 July 2026) as a plain-language rendering of its content, kept separate here from the clinical team's practical interpretation, which appears in Section 10.2. The national ruling of the UAE Council for Fatwa reproduced in Appendix A is the primary authority for this guideline; this Sharjah opinion is retained for reference as the preliminary basis on which ESCRS first sought guidance. It is not an official translation; institutions or individuals requiring an authoritative version should request it directly from the relevant Committee [12].

[Religious guidance] The Committee's ruling can be summarized, for clinical purposes, as follows:

- A patient who is medically required to wear a pouch attached to the abdomen to collect stool or urine, following a surgical procedure, is considered to be in one of two situations.
- If the patient is able to remove and cleanse the pouch before each prayer without significant difficulty, doing so is obligatory, since ritual purity is a condition for a valid prayer.
- If removing and cleansing the pouch before prayer is not possible, or would cause significant hardship, the patient's prayer while wearing the pouch — with the impurity it contains — is valid. This is based on the recognized Islamic legal principle that necessity permits what would otherwise be restricted, and that removing hardship is a core objective of Islamic law.
- A patient whose stoma output is continuous is treated, for ritual-purity purposes, similarly to a person with chronic incontinence: they should perform ablution (wudu) freshly for each prayer.
- The patient should pray in whichever physical position they are able to manage — standing, sitting, lying down, or by gesture — and is permitted to forgo attendance at Friday and congregational prayers because of this valid excuse.
- Where performing each of the five daily prayers separately would impose genuine hardship due to illness, the patient is permitted to combine Dhuhr with Asr, and Maghrib with Isha.
- If a patient who prayed with the pouch in place later becomes able to remove and cleanse it before the prayer's time has ended, it is recommended (though not obligatory) that they repeat the prayer.

The Committee closed its ruling with the standard formula acknowledging that God knows best, and it was signed by Qadi Saeed Abdullah Mas'oud Al Kaabi, Chairman of the Permanent Fatwa Committee of the Emirate of Sharjah [12].