Volume XL Issue No. 4 April 2010

Broward Beacon

Next Meeting:
Sunday, May 2nd, 2010, 1 p.m.

The Lueders
2100 South Ocean Drive #16M
Fort Lauderdale, FL 33316

Broward Ostomy Association

www.browardostomy.org

24 Hour Hotline (954) 537-0662

Shedding The Light Of Hope, Help, And Education For Ostomates Through Visitation & Rehabilitation. Published by the *Broward Ostomy Association,* a non-profit affiliated chapter of the *United Ostomy Associations of America* to aid Colostomates, Ileostomates and Urostomates.

MEETINGS: Held on the 1st Sunday of each month September through May and the second Sunday of June at 1:00 P.M. at the Memorial Regional Hospital, Main Auditorium, 3501 Johnson St., Hollywood. Directions: Exit I-95 at Hollywood Blvd. westbound. At 4th traffic light turn RIGHT (north) onto N 35th Avenue. Continue to second traffic light. Turn left following posted signs to Main Entrance. Free covered parking will be on your right and the Main Entrance will be on your left. The Main Auditorium is just off the main entrance lobby. A receptionist as well as security personnel are on duty to assist you.

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Broward Beacon

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President's Page

In a few days a local Middle School will be putting on the delightful musical *Annie*. Ever since I purchased tickets it's been really good for me to have the lyrics from *Tomorrow* running irresistibly through my head.

"The sun'll come out Tomorrow. Bet your bottom dollar that tomorrow there'll be sun! Just thinkin' about tomorrow clears away the cobwebs, and the sorrow 'til there's none! When I'm stuck with a day that's gray, and lonely, I just stick out my chin and grin, and say, 'The sun'll come out tomorrow so ya gotta hang on 'til tomorrow come what may. Tomorrow! Tomorrow! I love ya Tomorrow! You're always a day away!"

In 1978 I lived in Manhattan. I really wanted to see *Annie* which at that time had the original cast with Andrea McArdle, Dorothy Loudon, and Robert Fitch but the waiting time for tickets was over a year for that smash hit.

Then the miracle happened. New York City had the blizzard of the decade. All streets were closed and people walked through two feet of snow down the middle of the roads. It was a magical fairyland.

I rushed to put on my hat, coat and boots and walked many, many blocks to *Annie's* box office. All the ticket holders from NJ couldn't make it into town and I was able to get 3rd row center for that evening's performance. Indeed, the sun did come out for me that day.

Blessings come in all sizes and shapes but I mostly see their fingerprints in the smaller stuff. My prayer is that we're all encouraged, even if it has to be just in the smaller stuff. That's what BOA should be all about. Thank you for joining me to be encouragers one to another. We can be each other's sunshine today. Really looking forward to seeing you this May.

Fondly,

Wendy

P.S. Many of our members requested a copy of the recipe for the Cranberry Salad we had at our holiday banquet and when I forgot to put it in our newsletter they really got after me, so here goes:

2 large cans whole Cranberries
2 large cans jellied Cranberry Sauce
1 large can Mandarin Orange slices drained
1 small package Frozen Strawberries
8 oz. Walnuts

Coarsely chop walnuts and strawberries. Mix all ingredients together and chill in refrigerator overnight in a tightly covered bowl. Serves 15.

Ostomates on Mount Everest

via http://nogutsknowglory.com

At the end of March 2010, Rob Hill (adventure athlete, Crohn's patient, ostomate, Great Comebacks Global Ambassador and friend of UOAA) embarked on his final challenge in the *No Guts Know Glory Seven Summits Campaign*—tackling the highest peak in each of the seven continents. Everest is the last peak Rob needs to summit to complete his mission.

A feat only achieved by a handful of individuals to date, Rob will be the first Canadian with Crohn's disease and an ostomy to complete all seven summits. Rob was joined on his trek to Everest Base Camp by several other ostomates, including Tony Bell, Youth Rally counselor and 2009 Great Comebacks winner.

"The *No Guts Know Glory* team climbed to Camp One on Saturday April 17th, slept two nights and then returned to base camp. At present they are safe and sound resting in their tents. You can follow Rob and Tony's journey to the highest summit on Earth at: http://nogutsknowglory.com

Next Meeting:

Sunday, May 2nd, 2010
Refreshments, 1:00 p.m.
Chat 'n' Chew till 1:30 p.m.
Meeting: 1:30 p.m.

A few months ago I attended a luncheon where I heard one of the best speakers ever. She kept my attention almost to the point of my sitting on the edge of my chair and falling off. Afterwards I asked for contact information and was just totally thrilled that Joanne Brown, RN, MSN, LMBT-NC agreed to come and speak to BOA. Joanne will be sharing with us the role that stress plays in our lives, both good stress and destructive stress. More importantly, she will gave many specific how-to instructions on how to reduce the bad stress we all encounter in our lives. And as you already know, we as ostomates have special needs in coping.

I've put some of Joanne's suggestions to work and I can confirm that they do indeed work. Joanne is the Resident Nurse Coordinator for one of the largest retirement communities in south Florida.

Also be sure to pick up a free sample of Skin Tac and T3 in-pouch Odor Eliminator. I learned from LeeAnn, a nurse who is also an ostomate, that Skin Tac makes your skin really sticky and helps to prolong skin barrier life in problem situations. She could not make her skin barrier wafer stay put without it. However, she does warn that Skin Tac stings, so be careful when you try it.

Medicare and Ostomy Supplies

Excerpts from Medicare.gov

Medicare covers ostomy supplies for those who have a colostomy, ileostomy, or urinary ostomy. Medicare covers the amount of supplies the doctor says you need based on your condition. An order (prescription) must be on file with the supplier. It must be signed and dated by the treating doctor.

Make sure your supplier is enrolled in Medicare and has a Medicare supplier number. Suppliers have to meet strict standards to qualify for a Medicare supplier number. Medicare won't pay your claim if your supplier doesn't have a number, even if your supplier is a large chain or department store that sells more than just durable medical equipment

You pay 20% of Medicare-approved amounts. If a supplier doesn't accept assignment, there is no limit to what you can be charged. You also may have to pay the entire bill (your share and Medicare's share) at the time you get your supplies.

Ask if the supplier is a participating supplier in the Medicare program before you get your supplies. If the supplier is a participating supplier, they must accept assignment. If the supplier isn't enrolled in Medicare, Medicare won't pay your claim.

You must pay an annual deductible for Part B services and supplies before Medicare begins to pay its share. For more information call medicare at 1-800-633-4227.

WHAT WOULD YOU DO IF?

Ellice Feiveson, Metro MD. Via: Dallas Ostomatic News

Trust me, every ostomate has had or will have an "ostomy accident." By accident, I mean a pouch leak of some kind. The question is, "are you prepared in case an accident occurs away from home?" Not so much prepared as far as having a change of clothes and extra pouches, but prepared emotionally to deal with the unexpected mishap. The reality of it is that every ostomate must think of what he or she would do if at a party, in a restaurant, work or anywhere else, your pouch leaked because it wasn't on securely, or the clasp came off and the contents were spilling out.

The question is, "What do you do if you feel your pouch is not on securely or you feel wet around your pouch? First of all, you think that everyone is noticing you and knows what's happening. Stay calm.

Go to the nearest bathroom and take care of

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Broward Health's 9th Annual Wound & Ostomy Conference April 16th, 2010

Editor's Note: From 8 a.m. to 4 p.m. on April 16th CWOCN's Amparo Cano, Patty Paxton-Alan and Trish Corvino educated hundreds of nurses that work in the Broward Health network (Broward General Medical Ctr., No. Broward Medical Ctr., Imperial Pt Medical Ctr., Coral Springs Medical Ctr., Broward Health Weston, and the Chris Evert Children's Hospital) on Wound & Ostomy Care. What a thrill for me to attend and see so many nurses be brought up to date on issues of our needs and care.

There were two breaks where vendors of ostomy and wound care products exhibited their wears. Joe Meyers of Medline Industries showed me a wonderful product that is like a "super" Skin Prep. If for any problem such as a yeast infection you have to apply cream or powder under your skin barrier wafer (which makes it impossible for your barrier to stick) all you need to do is apply Marathon Liquid Skin Protectant over the cream or powder. It forms a wonderful dry crust which in turn allows your barrier to adhere properly. It appeared far more effective than Skin Prep so that multiple applications to form a "crust" are not as necessary. Joe will be trying to get samples for me to hand out at one of our future meetings. Remember, you don't need this type of product unless you're having a problem. Manufacturers of modern skin barrier wafers caution that adhesion improves without their use.

My sincere thanks to Amparo for allowing me to attend. I took notes like crazy and below is a synopsis of one of the great workshops.

The Patient with an Ostomy: Now What?

by Judy Papen RN, MSN, CNS, CWOCN
and Patti Ann Haberer RN, BSN, MA, CWOCN

Patti and Judy humorously used as reading lamp topped with a straw hat attached to a 22 foot length of fabric stretched along the side of our conference room to demonstrate just how incredibly long our intestinal tract is. After food leaves the stomach it enters our small intestine which absorbs most of our nutrients. The Small Intestine is 1.5 inches in diameter. Food then passes into the 5 to 6 feet of large intestine or colon which is 1.5 to 2 inches in diameter. This is where water is reabsorbed.

If stool or urine gets on an ostomate's skin the inflammation of Irritant Contact Dermatitis can occur. The underlying cause needs to be identified and then treated. The nurse should ask, "How long has the barrier been on?" Many times an ostomate will wear a skin barrier wafer too long, as most absorb moisture and melt out after three to four days of coverage.

Another question to ask is "Are you using the same pattern to cut the stoma hole in your skin barrier wafer that the nurse gave you in the hospital?" If the ostomate is, the hole is probably too large as our stoma diameter shrinks after surgery.

If the skin is denuded a procedure called "crusting" should be used. First you apply Stomahesive powder, then a layer of Skin Prep (or Marathon Liquid Skin Protectant). You may need to repeat layers until you get a "crust" over the irritated area.

If skin irritation is the same exact shape as the skin barrier wafer the ostomate probably has Allergic Contact Dermatitis which is just what it reads, an allergy to the product. The ostomate needs to use a skin barrier manufactured by a different company.

If an ostomate has a fungal infection surrounding the stoma, a 2% topical antifungal cream or powder should be used. This irritation has papules or pustules. Use the "crusting" method to cover the powder or cream.

Other stoma challenges include a flush to skin level stoma or a retracted below skin level stoma. A convex skin barrier wafer and perhaps a ostomy belt needs to be used. Barriers come with different levels of convexity, medium and deep. A retracted stoma needs the deeper convexity.

Any condition that compromises would healing such a nutritional problems, steroids or chemother-

apy may cause the skin around the stoma to separate from the stoma itself. The area needs to be packed with a surgical dressing that absorbs moisture.

Most ostomates should change their appliance first thing in the morning before having any drinks. The likelihood of output during changing is greatly reduced. Also never use any moisturizers or lotions under the wafer as adhesion is greatly reduced.

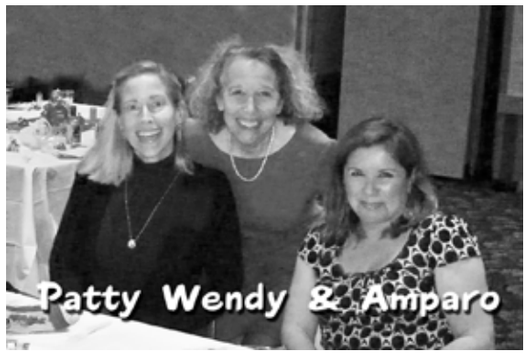
Whether to wear a two-piece or one-piece appliance is the decision of the individual ostomate and not the nurse except when a hernia or severe skin crease or fold is involved. In this case a one-piece with its greater flexibility is needed.

Both types have their advantages and disadvantages. A one-piece has a lower profile however, a two-piece allows the ostomate to change pouches without removing the entire product. The ostomate may wish to wear a mini-pouch for intimate moments or swimming.

A wonderful six-page full color flyer by Coloplast was distributed to all attendees which illustrated six different stoma types (firm abdomen, flabby abdomen, high output stoma, parastomal hernia, loop stoma with rod and a prolapse stoma) and five different views of flush or retracted stomas. Suggestions for each situation as to what type of pouching system to use, which kind of adhesive and whether convexity was needed were given. Types of ostomies and how they are constructed were illustrated along with peristomal skin conditions and stomal challenges and what to do about them. This was a great handout

All those attending were then given a three dimensional life size stoma model, pouches, wafers and scissors and then worked first hand on their appliance application techniques. I went to several tables and discussed how I changed and gave tips about the new moldable wafers that don't need to be cut with a scissors but merely molded to the correct shape with your fingers.

All of us should be very grateful for Amparo, Patty and Trish's hard work to educate health care professional on how to better care for us ostomates. Next time you see any of them at one of our meetings, be sure to give them a big hug and thank you.



Stoma Facts

by Diana Kasner, RN, MS, ET;
via UOAA UPDATE, December 2007

What is involved in "inspecting" a stoma?

At each pouch change, check your stoma for color, shape and function. Watch for problems such as swelling, retraction, stenosis and prolapse. Urostomates should be on the lookout for crystal formation of alkaline encrustation (gritty white deposits coating the stoma). Any stoma complications should be reported to your MD or Ostomy Nurse.

Why does a stoma sometimes bleed?

Some bleeding may occur with rubbing of the stoma because the mucous membrane out of which the stoma is formed is highly vascular. This bleeding should stop quickly. Prolonged bleeding, an increased amount of bleeding or very easy bleeding may be indicative of another problem and should be reported to your MD.

Can a stoma get cut?

Cuts or lacerations of the stoma can occur and some can be quite serious. Since a stoma has no pain nerves and, therefore, no feeling, it can be cut without causing any pain. Causes of stomal laceration include shifting of the faceplate or skin barrier, too small an opening (of the pouch), incorrect pouch application, etc. Your MD or Ostomy Nurse should be consulted for diagnosis and treatment in any case of stomal laceration.

continued on page 9

Time doesn't heal all wounds.

The Center for Wound Healing at Memorial Hospital Pembroke is dedicated to the prevention and treatment of chronic and hard-to-heal wounds.

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WHAT WOULD YOU DO IF? *continued from page 4*

business. Most likely, your friends are continuing their conversation in the restaurant or in your workplace and no one knows you are temporarily missing. When I encountered an accident while I was in a group situation, I just removed myself and took my time in freshening up and rejoined my friends. No explanation is ever necessary! The more outings you take and the more public situations you are in, the more confident you will be as time goes on.

ODOR MANAGEMENT

Greater Cincinnati Ostomy Association

Isn't it interesting that people with normal intact bowel tracts and urinary systems manage odor problems in an acceptable manner in our society? But when disease or trauma strike, and the person is the owner of an ostomy, the one big concern is the fear of offending society with an odor.

Basically, and simply, an ostomy is a man-made exit site that changes the point of exit from the bottom of our body to the front. Our eyes and nose are obviously on the front of our body, which leads us to be more aware of our changed body image and our odor-producing products. You've heard the statement "You've come a long way, baby." Yes, ostomy management has come a long way—considering that as little as ten years ago we had very few 100 percent odor-free pouches. When ostomy surgery was first developed, ostomates wore anything to collect output. Presently, almost all ostomy supplies available to us today are made of odor-barrier materials.

Therefore, if an ostomate does have a fecal or urinary odor about them, some detective work should be done: Check out the application of the pouch to the body—is it leaking? Check out the closure of the pouch—is it closed properly so that no fecal matter is oozing out after the closure is applied? Do not put holes in the pouch as gas will seep out continuously.

A urostomate should rinse or wipe off the spout of the pouch with a bathroom tissue after emptying. Those few drops left in the spout after closing the pouch can cause a urine odor under clothing. It's interesting to note that most urostomy pouches on the market are odor-proof, but the connector tubing and bedside and leg bags are not.

You must dispose of and replace these products when they take on odors, or else your entire living quarters will smell.

Emptying an ostomy pouch is comparable to a person with an intact bowel or urinary tract having a bowel movement or emptying their bladder. How does the non-ostomate handle the odor produced by this normal function of their body?

Room deodorizing sprays are popular; a quick flush of the toilet when defecation occurs, and striking a match or opening a window are some acceptable methods that have been used for odor management since the invention of indoor plumbing.

Why then are we ostomates so "up-tight" about the odor produced when our pouches are emptied? This complaint has encouraged ostomy supply manufacturers to create products to meet this need of "odor control." The trouble is, the ostomy deodorants do not work for everyone and they are expensive. Can we then consider ourselves "as normal as blueberry pie" so far as waste odors are concerned? Just remember, there is not a man or woman on this earth whose wastes do not smell. If someone tell you their waste products are odorless, then a nose overhaul is in order.

Stoma Facts *continued from page 7*

How should a stoma be protected?

Stomas are fairly hardy, but some common sense rules apply. Stomas should be protected from direct physical blows, from too tight clothing and from rigid objects (e.g., belt buckles). This is not to say that these activities should be avoided. For example, ostomates engaged in contact sports can protect their stomas by wearing an additional binder for support.

Mark your Calendars

If you're as forgetful as I am, please mark your calendars for the following 2010 meeting dates: May 2nd, June 13th (second Sunday), summer break, Sept. 5th, Oct. 3rd, Nov. 7th and Dec. 5th.

Memorial Hospital West's Ostomy/Wound Outpatient Clinic

For advice on pre and post operative ostomy care including stoma site selection, ostomy product selection, peristomal hernia belt fitting, treatment of peristomal skin complications and complex fistula/tube management, this clinic is for you.

For information or to schedule an appointment with Eula Fahie-Romero, Certified Wound and Ostomy Nurse, please call 954-844-6834. Outpatient Clinic Hours are from 1 p.m. to 3 p.m. every Thursday at Memorial Hospital West.

Coral Springs Ostomy Support Group

Coral Springs Medical Center's "Caring & Sharing Ostomy Support Group" meets on the 4th Wednesday of the month at 5:30 PM - 7:00 PM in. For more information, call Patricia Paxton-Alan MSN, ARNP-BC, CWOCN at 954-344-3094.

Impact of Abdominal Changes

By Arthur Clarke, CWOCN

Only a finite amount of bowel eligible for use in the creation of a stoma. When you had your ostomy surgery, the surgeon was allowed—according to your personal physiology—only so much moveable bowel in the construction of a quality ostomy stoma. Once that piece of bowel was pulled through your abdominal wall, it was stitched to the inside of to abdominal wall and onto the outside of the skin.

The length originally chosen by the surgeon will remain constant throughout the patient's life. Therefore, if the wall of the abdomen thickens: i.e., fat accumulates on the abdominal wall due to increased weight or lack of exercise, the length of the bowel segment used in the creation of the stoma will not change to accommodate the patient's increased girth.

This being the case, one might expect the stoma to appear to be receding, since it and the peristomal skin cannot expand with the thickening abdominal wall all around it. This is in fact what happens. This condition is further exacerbated with the patient move from a standing to a sitting position.

This change in position causes the abdominal wall to move forward and down. However, the fixed dimension of the stoma bowel segment prevents the peristomal skin from shifting as much as the rest of the abdominal wall. The result is formation of a skin well around the stoma, especially when changing from one physical position to another.

The welling effect and excessive stress on the peristomal skin will most assuredly result in difficulty developing and maintaining the integrity of the skin barrier's seal. Ultimately, this results to untimely and frequent leakage challenges.

There are two main approaches to resolve this issue. The ideal approach is for the patient to make a conscientious effort to maintain a constant and healthy weight, thereby returning the abdomen to the shape and wall thickness present at the time of the surgery. This approach would require regular exercising to firm up one's body as well as maintaining the correct weight for one's physical attributes.

If one is unsuccessful with this approach, an option in pouching management is to switch from one's current pouching system to a convex pouching system. Many have found that a skin barrier with a convex surface—this has the effect of pushing the skin down and popping the stoma out—works much better than the highly flexible flat skin barriers.

If you find yourself in a position where abdominal changes affect the integrity of your pouching system, there are positive solutions available. Should you experience any difficulty making the switch to a convex pouching system, enlist the aid of your local ostomy nurse. Convex pouching systems are being used successfully by people with ostomies with flat or retracted stomas, and they have been for a sufficiently long time to prove their worth

BOA does not endorse any products or methods. Consult with your doctor or ET Nurse before using any products or methods either published in this bulletin, displayed, described, demonstrated or distributed by sample at our meetings or recommended by an association member.

Broward Ostomy Association Membership

If you wish to be a member of BOA dues are $10.00 per year from January 1st to December 31st and includes receiving our monthly newsletter, the ***Broward Beacon.*** Please make checks payable to BOA and mail to Treasurer Mr. H. Lynn Ward, 1704 N 32nd Ct, Hollywood, FL 33021-4427. BOA never shares membership information. We value your privacy.

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__ I am an ostomate and want to be a member but cannot afford dues at this time.
(This information is kept in the strictest confidence.)
__ I would like to become an Associate Member (non-ostomate).

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