Volume XLI Issue No. 3 March 2011

Broward Beacon

Next Meeting:
Sunday, April 3rd, 2011: 1 p.m.

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

Broward Ostomy Association

An affiliated chapter of the United Ostomy Associations of America.
Our Vision ~ a society where people with ostomies are universally accepted and supported socially, economically, medically and psychologically.

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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President's Page

On a personal note Ren and I celebrate every anniversary I can think of. This past week was the 31st of our becoming engaged to be married. For me, just about any excuse for a night out on the town will do. Thanks Ren. And for those who have been kind enough to inquire about my health, I'm doing great.

In this month's issue please be sure to read the terrific article starting on page six. I read and sift through innumerable articles to try and bring you the best, and this article is indeed one of the most interesting I have come across. I emailed the author to confirm permission to share it with you and she graciously concurred.

As promised, if I learn of mistaken information that I've previously shared I would humbly admit to my error. Well, it's happened again. Bottom line is that I'm confirming the concept that what works well for one ostomate does not necessarily work well for another. When I was a philosophy student my professor would call my error 'jumping from the experiential to the normative". To point: previously I have cautioned against sleeping on your tummy or wearing tightly fitting clothes for fear of blocking the output into our surgical appliances and thus causing a leak e.g. if the output can't find it's way into the pouch it would be forced to go sideways onto your skin. Wrong!

Since that was the case for me personally I thought it must be true for everyone else. What I have learned recently that corrects my mistake is that this type of leak only occurs if you have a certain type of stoma. Now that my stoma is far more recessed I can and do wear tight clothes and sleep on my tummy with absolutely no problem. If you want to wear tight clothing or sleep facing down, experiment and see if it works for you. It may or it may not.

How fortunate that we're all unique. What we have in common though is that our bodily functions don't define who we are and that ostomates can and do live full and complete lives. Remember, the new normal for an ostomate is leaking very, very infrequently, smelling like a rose and feeling completely comfortable with your appliance. If any of these criteria are missing from your lives, please make an appointment to visit a CWOCN just as soon as possible so you can get on with and enjoy living. On our website is an article on how to contact the ostomy nurses in Broward County under the heading *Newsletter Articles*. Don't settle for less. You're worth it.

Looking forward to seeing you this April.

Fondly,

Wendy

Welcome to Lea Crestodina!

Welcome to our new Medical Advisory Board Member Lea Crestodina ARNP CWOCN CDE, RN. Lea, along with Chris Poole Johnson run Memorial Hospital's Ostomy Outpatient Clinic to benefit ostomates and their families.

BOA is so blessed to have five such competent and compassionate ostomy nurses on our Medical Board giving of their time and talents to us throughout the year. Our sincerest thanks for all you do. A whole lot goes on behind the scenes to make BOA run and these five wonderful ladies always make themselves available to help us out. Bless you and thank you.

New Product News

The *Ostomy Bag Squeegee*© is a new device for ostomates which may be especially helpful for whose of us with arthritic hands.

Its scissor-like design enables ostomates to push out the contents of drainable ostomy pouches quickly and efficiently with the potential of greatly reducing cleanup, accidents and spills. It is made of stainless steel, is washable, easy to use and lightweight. Ordering details are presently unavailable but will be soon. Their website states, "The first 3,000 orders will receive 50% off the normal price!" We will let you know as soon as possible how it can be ordered.

Next Meeting:

Sunday, April 3rd, 2011
Refreshments, 1:00 p.m.
Chat 'n' Chew till 1:30 p.m.
Meeting: 1:30 p.m.

Due to their incredibly busy schedules, it is with great delight and gratitude that we welcome Henry Wodnicki, MD as our April Guest Speaker. Dr. Wodnicki is a Board Certified specialist in Colon/Rectal Surgery at Memorial Regional Hospital and just recently joined their staff. Fortunately his care philosophy is to treat all with kindness and professionalism.

He completed surgical residencies at St. Barnabas Medical Center in Livingston, NJ, and at Mount Sinai, as well as a fellowship in colon and rectal surgery at Baylor University Medical Center in Dallas, Texas. We are thrilled to welcome him to our local community and truly look forward to learning from an expert.

MINUTES – March 2011

More than 50 people attended the March 6, 2011 meeting which President Wendy opened promptly at 1:30 p.m. Mary Lou, a CWOCN from Cleveland Clinic in Weston, FL read the Ostomate's Prayer and was nominated to the Medical Advisory Board of our Broward Ostomy Association (later voted in at the Board meeting which followed this general meeting). Wendy noted that we had four CWOCNs (Certified Wound Ostomy Continence Nurse) at our meeting today. Four first time visitors were also welcomed; Jack, Mitch, Phyllis and Richard.

Helen Ginsberg was present with her daughter and granddaughter. Helen is the person to contact if you would like to be reminded by phone of each upcoming meeting. Certified WOCN Lea Crestodina reminded us that there is an outpatient ostomy clinic at Memorial Regional Hospital. Patients can contact her at MRH for details on arranging an appointment.

A Travel Communication Card was distributed at today's meeting to help meet Transportation Security Administration guidelines if you are traveling with an ostomy device. The Card explains that you may need immediate restroom access and carry related ostomy supplies or catheters.

Wendy announced that there will be a Board of Directors' meeting after the regular meeting today in the auditorium. In August, Wendy will be traveling to the UOAA National convention in Reno, NV as an advisor to their national Board.

Vice President Amy introduced Dr. Alok Shrivastava, Head of Cleveland Clinic Florida's Section of Robotic Urologic Oncology. Dr. Shrivastava presented a talk entitled *From Blood and Guts to Bits and Bytes*. The da Vinci Surgical Robot is the primary tool by which he and others perform surgery for prostate and bladder cancers. The surgeon controlled robot was originally used for heart surgeries and for remote operations on injured military personnel overseas. A substantial financial donation allowed the development of the techniques and tools the doctor and his team currently use.

The robotic surgical system gives the surgeon a magnified 3D view of the surgical site, much like an IMAX 3D movie, and requires the use of polarized 3D glasses. Assisting technicians and physicians can

Pattie Amparo Mary Lou Lea

continued on page 9

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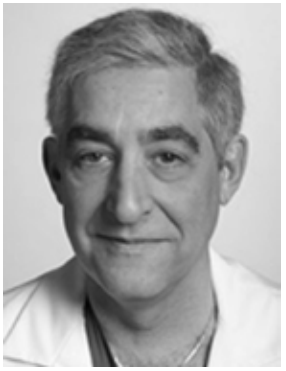
Ask the Surgeon Forum with Stephen R. Gorfine, MD Clinical Professor Surgery Mt. Sinai Medical Center

by Ruth Grossman & Diane Watkin, LMSW, President, Ileostomy Association of New York, Nov. 2010 Bulletin



What is new: 1. Laparoscopic surgery can now be utilized to do the same kinds of work as open surgery. The advantages of laparoscopic surgery are shorter hospital stay, less discomfort, improved cosmetic result, and fewer adhesions and incisional hernias.

There are several newer techniques emerging: 1) SIL, or single incision laparoscopy (usually through "belly button"); 2) "NOTES", or natural orifice trans endoscopic surgery (e.g., remove gall bladder through the vagina), "NOTES" is in being performed on experimental animals, not yet applied to humans. Although it avoids the necessity of surgery though the abdominal wall, it unlikely to be popular.

2. **Fast Track Approaches**: It appears that devices such as NG tubes and bladder catheters inhibit, rather than promote a faster, easier recovery following surgery.

3. **Parastomal hernia repairs**: Fewer complications such as infections are associated with the use of biological mesh than the older plastic mesh. Biologic (collagen) mesh is associated with a decreased rate of recurrence, compared to repair without the use of mesh. Those currently available act as a framework to provide a scaffold with which the body's cells integrate. It appears promising, reducing recurrence from about 30% to 10%.

Hernias arise from the weakness in the abdominal wall which arises when a surgical opening is created for the stoma. If the opening is too narrow, the intestine can become constricted; too large, and hernia may develop. Hernias may occur immediately after surgery or years later. Although the stoma is created through the rectus muscle for optimal result, the weakness remains in the fascia. One can strengthen the rectus muscles with exercise once permitted after surgery, but one cannot strengthen the fascia.

A similar, but naturally occurring weakness may lead to inguinal hernias in men, due to the passage of the seminal duct from the testicle to the prostate. It is important to note, however, that neither all men nor all ostomates develop hernias as a result.

Skin problems surrounding the stoma can be difficult to manage. The necessity of the skin barrier precludes multiple daily topical applications. In addition, the prescribed ointment or cream can interfere with adherence of the pouching system. While there are specific conditions associated with an ostomy (pyoderma gangranosum) such general conditions as psoriasis or rosacea may also occur. Non adhesive systems would accommodate the need for multiple topical applications. In general, dermatologists are less familiar with skin issues as they relate to ostomy management than the WOCN's (ostomy nurse).

Types of Intestinal Diversion Surgeries:

The surgery that has been around for the longest period of time is the is the permanent end ileostomy, in which the colon, rectum and anus are removed and the latter closed. This has an overall complication rate of about 15%, These complications include prolapse, parastomal hernia, peristomal dermatitis, etc. For individuals with ulcerative colitis, it removes the disease. It is perfectly possible to live well without a colon, as its only function is to absorb water and form stool. Although an external pouch is required, it poses no obstacle to a full and active life.

Kock pouch or Barnett type procedure: (continent ileostomy) This procedure became popular from about 1969-1979 and usually performed in specialized centers. Although a stoma is created on the abdomen, it is flush with the skin, and no external pouch is needed. An internal reservoir is created

from intestine and is emptied via a catheter inserted into the stoma. However, the valve responsible for maintaining continence was at high risk for failure. It has an overall complication rate of about 25%. The reoperation rate is about 15%.

Restorative proctocolectomy e.g. J pouch. The J pouch has been around since 1979. When surgery was initially introduced, the age limit was under 40. Currently the surgery is performed on persons in their 70's. This may be surgery of choice for many individuals with ulcerative colitis or dysplasia with ulcerative colitis. Individuals with Crohn's disease are generally not good candidates for the surgery. A strong, working sphincter is necessary.

There is controversy regarding a situation where there is dysplasia in the rectum since part of the surrounding tissue has to be left in order to create the J pouch. Otherwise there are no fixed criteria, choice can be one of lifestyle.

In this procedure the colon and rectum are removed, but anal muscles are left. A new rectum is created from the small intestine and connected to the remaining bowel. A loop ileostomy is created to protect the anastamoses ("joints").

There are potential problems and complications, such as if healing does not occur where pouch meets the anus, leakage and fistula. A good result is 4-6 bowel movements per day (without the urgency) that have the consistency of baby food. 15% of individuals will have leakage of mucous or stool at night. The overall complication rate is 56%, based on a 15 year follow-up period. Pouch loss rate is approximately 3 in 100. Revisional surgery for stricture is about 11% and for fistual/abscess about 8%. (All of these complications, as well as lesser problems such as pouchitis and perianal irritation, comprise the 56% overall complication rate).

Reversal time for J pouch: The shortest recommended period of time is usually 100 days (3 months) to allow for healing. It is possible, and sometimes desirable, to wait longer. For individuals who are very ill due to IBD, underweight, malnourished, and on high doses of steroids, an ileostomy is usually created, and a subtotal colectomy performed, The rectum and anus left intact with the option of creating a J pouch later. It is desirable to achieve optimal weight, and blood count, and regain strength and stamina (which may take a year) before undergoing additional surgery. There is no upper time limit. J pouch surgery interferes with a woman's ability to conceive due to the formation of scar tissue in the fallopian tubes. Women may therefore elect to remain with an ileostomy during their childbearing years.

Adhesions: Adhesions form when working within the abdominal cavity. It is scar tissue that develops around organs and causes tissues to stick together.. The use of "Seprafilm", an FDA approved product that looks like sheets of cellophane can help prevent adhesions - it keeps organs apart during the healing process and then melts away. However, it only works where it is physically placed. (A liquid form of it would be highly desirable.) It must be kept away from areas of anastomosis, as it is critically important that the connections knit together. Surgery can be used to resolve problems created by old adhesions, but the process of surgery can create new ones.

Cancer and Inflammatory Bowel Disease: An attendee reported a history of 20 years of ulcerative colitis, and a narrowed colon which did not allow examination beyond the sigmoid colon. Dr. Gorfine explained that after 7-8 years, one incurs the risk of dysplasia, which is considered a pre-cancerous condition. Risk of developing cancer increases by 2% every year thereafter. The only way to find dysplasia is through multiple random biopsies during yearly colonoscopies. Narrow band imaging and dye spray can help direct biopsies. However, these biopsies represent only a minute proportion of the colon, so it is possible that even if one does everything one is supposed to, a late stage cancer can occur. The standard colonoscopy failure ("miss") rate is 5%. . In such a situation, surgery is recommended, even without the benefit of recent colonoscopy results.

Virtual colonoscopies only pick up lesions above the surface, such as polyps. They do not find abnormal areas that are flat. Like standard colonoscopies, prepping is required and air is inserted into the colon. Unlike regular colonoscopies, biopsies cannot

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BOA Minutes *continued from page 4*

share the same detailed view on a 110 inch monitor. The specially trained surgeon controls the robot by wearing sensors that allow specialized instruments on the robot's four arms to mimic his hand and finger movements with great precision. Advantages of robotic surgery are that it is minimally invasive and requires much smaller incisions. Hospital stays are shorter, there is less blood loss, less pain, catheterization time can be reduced, there is a lower risk of infection, and the recovery period is greatly reduced.

Wendy asked how does the loss of the surgeon actually feeling what he is doing affect the surgery. Dr. Shrivastava said that touching the internal organs with gloved fingers can actually cause more nerve damage and adhesions. The magnification and various 3D views provide more valuable information than a surgeon's sense of touch.

Doctors hope to develop techniques to perform robot assisted colon and rectal surgeries including ileostomies and colostomies in the near future, as funds become available for the necessary research. Insurance issues are a concern, and the doctor added that patient safety is paramount in developing new techniques.

Wendy awarded a Certificate of Appreciation and her famous speaker's brownies to Dr. Shrivastava. The meeting concluded at 2:25 p.m.

Respectfully submitted,

Bill

Bill Wilson
Recording Secretary

Types of Accessories

via Hot Springs Ostomy Association

You may need or want to purchase certain pouching accessories. The most common items are listed below.

Convex Inserts: Convex shaped plastic discs that are inserted inside the flange of specific two-piece products. These push your skin around the stoma in toward your body helping to make a more secure bond for stomas that don't protrude very far from your body. Many skin-barrier wafers come with built-in convexity. Call the individual manufacturers for details.

Ostomy belts: Belts that wrap around the abdomen and attach to the loops found on certain pouches. Belts can also be used to help support the pouch or as an alternative to adhesives if skin problems develop. A belt may be helpful in maintaining an adequate seal when using a convex skin barrier. Belts can be uncomfortable and should only be used if necessary. The tape around skin-barrier wafers is usually more than adequate to support an ostomy pouch even when it is full of contents. The tapes used today actually adhere more strongly after they become wet so don't avoid water.

Pouch Covers: Made with a cotton or cotton blend backing, easily fit over the pouch and protect and comfort the skin. They are often used to cover the pouch during intimate occasions. Many pouches now include built-in cloth covers on one or both sides, reducing the need for separate pouch covers.

Skin barrier Paste: Paste is used as a caulking material; it is not an adhesive. Paste can be used to fill in folds, crevices or other shapes or surface irregularities of the abdominal wall underneath the wafer, thereby creating a better seal. A more lasting product than paste is a "silly putty" like washer such as Eakin Cohesive Seals by ConvaTec which do not breakdown as quickly.

Tapes: Tapes are sometimes used to help support the wafer or flange (faceplate) and for waterproofing. They are available in a wide range of materials to meet the needs of different skin sensitivities. Pink waterproof tapes are very hard on the skin and should only be used with caution. Remember, never pull your skin to remove tape as this is very harmful. If tape is sticking too well to remove easily by pushing your skin toward your body, be sure to use Adhesive Remover wipes to get it off.

Ask the Surgeon *continued. from page 7*

be performed as part of the procedure.

Capsule endoscopy involves swallowing a miniature camera which transmits images as it passes through the intestinal tract. It is most useful to investigate the small bowel and find duodenal ulcer, but it does not work as well in the colon. If the intestinal tract is narrowed due to scarring/adhesions, it has the potential to cause a blockage and require surgical removal.

Lynch Syndrome: is a hereditary cancer syndrome in which individuals are prone to cancers at an early age, specifically bowel/gynecological cancers. Blood tests can indicate if one has this mutation. If one has developed cancer, a sub total colectomy procedure is recommended. If one hasn't developed cancer the question is one of risk tolerance and when one starts to worry. The odds of developing a cancer increases once one reaches one's fifties, but unlike certain other genetic diseases such as Familial polyposis, not everyone will go on to develop cancer.

Short Bowel Syndrome can occur when so much small bowel has been removed that an individual does not have the capacity to maintain nutrition and hydration. Unlike the large bowel, with which one can live without, the small bowel is essential for absorption of nutrients. It may occur following multiple surgeries to small bowel, for Crohn's Disease. Certain narcotics can help slow down transit time, vitamins and glutamine can be given as supplements, or a person can receive hyperalimentation (parenteral nutrition) through a vein. Small bowel transplants are another emerging option for situations that cannot be managed by other means.

Bleeding with Bowel Movement: The most common cause is an anal problem. Benign anal fissures are common in young people. Bleeding can occur due to hemorrhoids which are special vascular structures present in everyone. Bleeding is not "normal" and does need to be investigated further. Causes could be skin lesion, fistula, cancer, or a stomach or duodenal ulcer. Generally speaking, a darker color of blood indicates a problem higher up in the digestive tract.

Mesenteric Vein thrombosis/Portal Vein thrombosis is a potential complication of ostomy surgery, and may be responsible for more postoperative pain than previously thought. The mesentery is a sheet of tissue that holds organs to the body. The mesenteric veins drain into the big portal vein which leads to the liver, which then purifies the blood that circulates to the rest of the body. Sick individuals - those with cancer, ulcerative colitis, Crohn's disease have blood that tends to coagulate more. Thus the concern regarding blood clots in the leg following surgery which can dislodge and travel to a vital organ. CAT scans will pick up evidence of blood clots. They generally go away by themselves. Otherwise, treatment with heparin usually resolves the problem.

Colon Transplants: Since the only function of the colon is to absorb water, and one can live a perfectly healthy life without the large intestine it does not makes sense to incur the type of risks that any organ transplant entails, i.e., lifelong treatment with immunosuppressants, increased pneumonia risk, etc.

Long Term Health problems for Ileostomates: There are no special considerations except the need for more hydration, than a person who has their colon, as the colon is responsible for absorption of water.

Coral Spring Ostomy Support Group

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

BOA does not endorse any products or methods. Consult with your doctor or Ostomy 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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