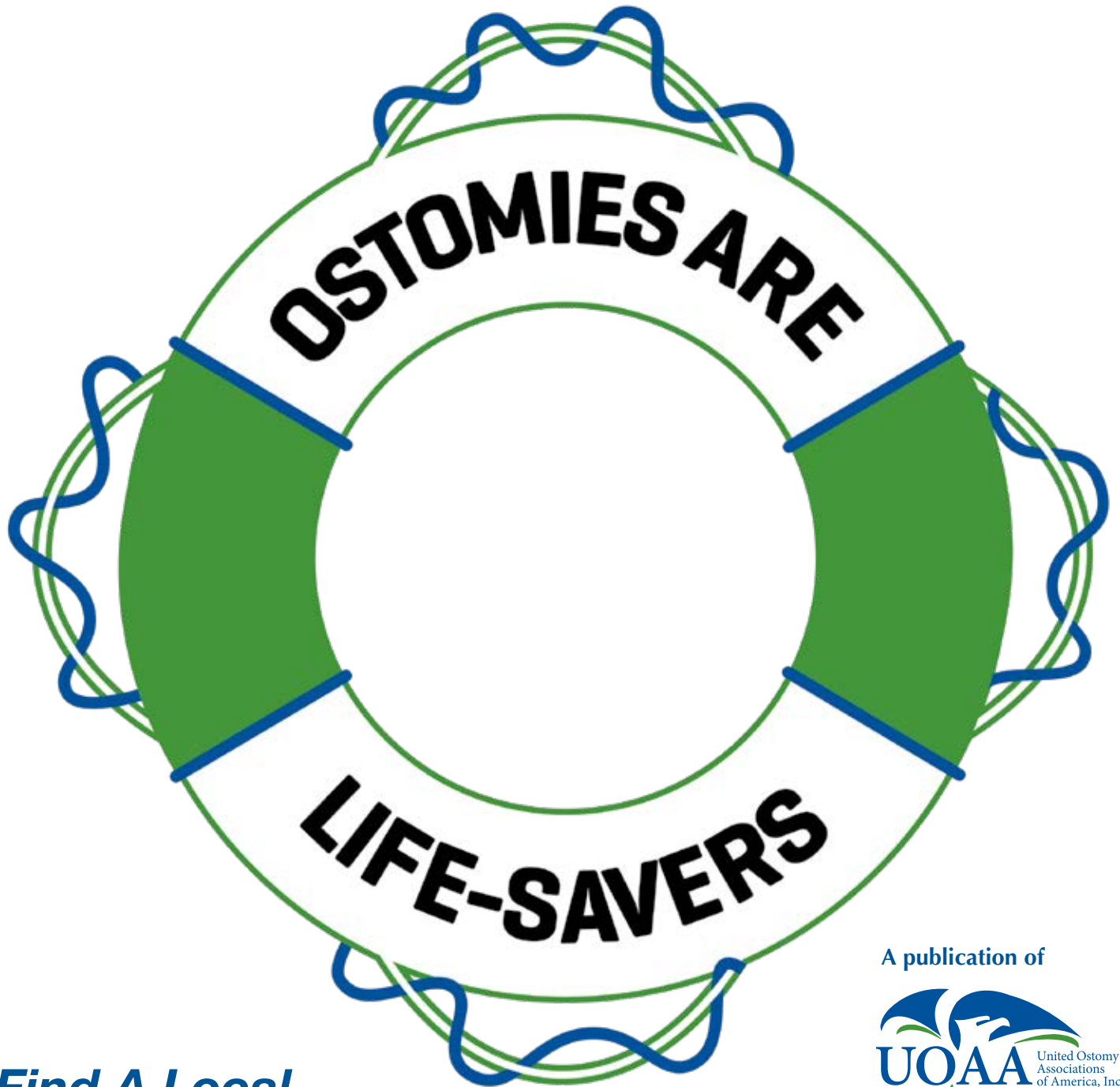


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# New Ostomy Patient Guide

## Ostomy Basics

- 6 What is an Ostomy?**  
*By Cliff Kalibjian*
- 12 Ostomy A to Z**  
*By Cliff Kalibjian, Revised by  
Joanna Burgess-Stocks, BSN, RN, CWOCN*
- 18 A Successful Recovery**  
*By Diana Gallagher, MS, RN, CWOCN, CFCN*
- 20 Ostomy Reversals**  
*By David E. Beck, MD, FACS, FASCRS*
- 22 Peristomal Hernias**  
*By David E. Beck, MD, FACS, FASCRS*
- 24 Peristomal Skin Care**  
*By Joan Junkin, MSN, APRN-CNS, CWOCN*



## Product Guide

- 26 One-Piece Vs. Two-Piece**  
*Adapted from Pouching Systems Patient Educational Sheet*
- 28 Five Reasons Pouches Leak**  
*By Anita Prinz, RN, MSN, CWOCN*
- 32 Peristomal Skin Products**  
*By Joy Boarini, MSN, WOCN*



## Colostomy Care

- 36 Basic Colostomy Care**  
*By Leslie Washuta, RN, BSN, CWON*
- 43 Colostomy Irrigation**  
*By Ian Settlemire, The Phoenix Magazine Editor*
- 46 Beautiful Butterfly**  
*By Charles Redner*



## Ileostomy Care

- 48 Basic Ileostomy Care**  
*By Leslie Washuta, RN, BSN, CWON*
- 54 The Pilates Pro**  
*By Ryan Hodgkinson*
- 56 Short Bowel Syndrome**  
*By United Ostomy Associations of America*

## Urostomy Care

- 58 Basic Urostomy Care**  
*By Joy Boarini, MSN, WOCN*
- 60 Urostomy Pouching Systems**  
*By Leslie Washuta, RN, BSN, CWON*
- 62 Ballroom Dancer**  
*By Jadranka Vrsalovic Carevic*

## Continent Diversion

- 64 Continent Bowel Diversions**  
*By Gregg I. Shore, MD, FASCS, FASCRS*
- 68 Continent Urinary Diversions**  
*By Roni Olsen*

## Lifestyle

- 70 Dietary Considerations**  
*By Sharon Osgood, BSN, RN, CWOCN and  
Christina Handschuh, RD*
- 74 Swim Confidently**  
*By Ed Pfueller, UOAA Communications Manager*
- 75 Travel Tips**  
*By United Ostomy Associations of America*
- 76 Intimacy**  
*By Laura Herbe BSN, RN, CWOCN*
- 78 Back to Work**  
*By Jeanine Gleba, UOAA Advocacy Manager and  
Ed Pfueller, UOAA Communications Manager*

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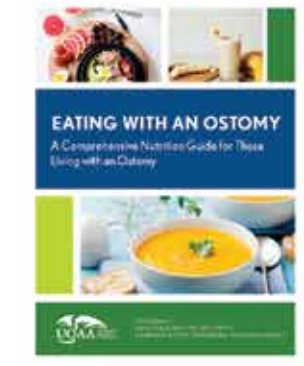
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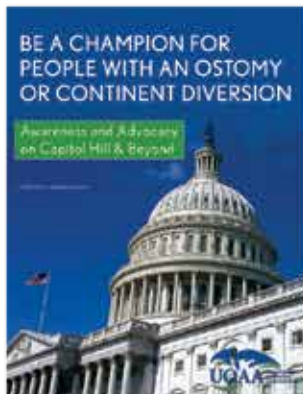


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# What is an Ostomy?

## Understanding the main types of ostomy surgeries used today

By Cliff Kalibjian

An ostomy is a surgical creation of an abdominal opening that enables a connection from an internal organ (such as the intestine) to the skin surface. In many cases, the purpose is to allow the elimination of bodily waste products, such as feces. However, if higher up in the gastrointestinal (GI) tract, an ostomy can be used for intake purposes as well (i.e., feeding).

The opening of the ostomy on the skin is called a stoma, a term of Greek origin, meaning “mouth.” For gastrostomies and jejunostomies, the stoma, indeed, often functions as a mouth so that a person can receive nutrients that they wouldn’t otherwise be able to eat or drink. For other ostomies, usually in the lower parts of the GI tract, such as ileostomies and colostomies, the stoma effectively functions as an anus, requiring many people with these types of ostomies to wear special types of pouches to hold waste.

Statistics on ostomies remain somewhat elusive in the United States, which in part have to do with reporting/coding processes that are used for tracking various medical procedures. Estimates of the number of people with ostomies in the U.S. range anywhere from about 750,000 to 1 million with approximately 100,000 new ostomy surgeries performed each year. Many of these are temporary, meaning that the person is expected to eventually – often within a year – have the procedure reversed (they’ll have a follow-up surgery to remove the ostomy and reconnect the intestine).



*Figure 1. A colostomy is created when the colon (large intestine) is brought through the abdominal wall.*

The sections below review the major types of ostomies as well as the most common continent procedures for bowel and bladder diversion.

### Colostomy

A colostomy (Figure 1) is a surgically created opening in the colon, also known as the large intestine, that is brought through the abdominal wall to create a stoma. Intestinal waste will exit the stoma into a pouching system.

In most cases, the colostomy is made from the descending or sigmoid colon (area above the rectum), with the stoma on the left side of the abdomen. Because most of the colon still remains, output is solid and not very irritating to skin.

Colostomies can be permanent or temporary, depending on the reason they were created. Permanent colostomies are necessary

when the anal/rectal area needs removal due to severe disease or serious trauma.

Common reasons for colostomy surgery include colorectal cancer, diverticulosis, Crohn’s disease or anal cancer as well as birth defects or a nonfunctioning colon.

A pouch can be worn to catch stool, but colostomates may have the option of irrigation to control when body waste exits the stoma. Water is passed through the stoma to stimulate a bowel movement. See “Colostomy Irrigation” on page 43.

### Loop and Barrel Colostomy

In a loop colostomy, a section of colon is brought through the abdominal wall in a way that results in two openings. One is “inline” and will expel stool. The second opening is disconnected and no food matter or waste will pass through it; however, it will secrete mucous. These are sometime referred to as a mucous fistulas.

A loop colostomy can essentially be managed as one stoma, even though it technically has two openings. It’s best to work with a knowledgeable ostomy nurse to help set up a secure pouching system, which will likely be needed for at least two to six months, after which a reversal may be considered.

Another somewhat similar surgical option is what’s called a double-barrel colostomy. Instead of only partially cutting the intestine and creating a loop stoma with the two openings, the surgeon fully severs the bowel (typically in the transverse area if in the colon), usually due to a bowel segment

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between the two ends that needed removal. One end is connected to the active digestive tract and will expel stool, while the other is connected to the bypassed area of bowel and will only pass mucous.

Both ends of intestine will be brought through the abdominal wall. If placed right next to each other, they will resemble a double-barrel gun, hence, the name. Placement of double-barrel stomas



*Figure 2. An ileostomy is formed when the last portion of the small intestine (the ileum) is brought through the abdominal wall.*

are crucial, because if not planned smartly, the pouching adhesive that will be required for the active stoma will get in the way of the stoma that releases mucous (called a mucous fistula). Having them spread further apart, if possible, may be a good choice so that there will be no chance of this issue.

The mucous fistula will not likely require a pouching system. Keeping it covered with a clean gauze pad should be sufficient in most cases. Also, in addition to double-barrel colostomies, it's possible (and not uncommon) for the first "barrel" (active stoma) to actually be an ileostomy stoma and the second

"barrel" (the mucous fistula) to be a colostomy stoma.

For some individuals, it may not be necessary to bring the end of intestine connected to the bypassed bowel to the skin surface as a mucous fistula. If there is no chance of narrowing or blockage downstream, the end of the intestine can be sewn shut and placed inside the body. Mucous generated in the bypassed segment of bowel can



*Figure 3. A loop ileostomy is formed when small intestine is brought through the abdominal wall and two openings (stomas) are made.*

then flow out through the rectum and anus. This is known as the Hartmann's pouch.

### **Ileostomy**

An incontinent ileostomy, also known as a Brooke or end ileostomy (Figure 2), is a surgically created opening in the ileum, the last part of the small intestine, that is brought through the abdominal wall to create a stoma. Brooke ileostomy stomas are generally round and about an inch in diameter and located on the lower right side of the abdomen.

Common reasons for ileostomy surgery include severe inflammatory

bowel disease (i.e., Crohn's disease or ulcerative colitis) and familial polyposis, a hereditary condition where polyps (small growths) develop throughout the colon at a young age and can easily turn into cancer.

Drainage is often liquid-like after surgery, but the small intestine eventually absorbs more fluids and electrolytes as the colon had once done, and output becomes thick or mushy. Proper hydration, however, is still essential, and people with ileostomies are generally advised to consume potassium rich foods (e.g., bananas, potatoes, oranges) and not go out of their way (unless otherwise advised) to limit sodium (salt) intake.

Ileostomy output is full of digestive enzymes, so it's important to work with an ostomy nurse to choose a good pouching system that properly protects the peristomal skin. A pouch needs to be worn at all times since output is frequent and often unpredictable.

### **Loop Ileostomy**

This variation of the incontinent ileostomy is usually used to allow a section of bowel to heal. For example, if a person has a diseased segment of their large intestine removed and then the healthy sections sewn back together, the sutures need time to heal so a loop ileostomy is created to allow waste products to exit the body before the anastomosis.

A segment or "loop" of the ileum is brought through the abdominal wall and above the skin surface, then the surgeon cuts the wall of intestine, but does not completely sever it, which results in two openings (Figure 3). One is "inline" and will expel stool, the other is now disconnected and no food matter or waste will pass through it. This second will secrete mucous (hence, it's sometimes referred to as a





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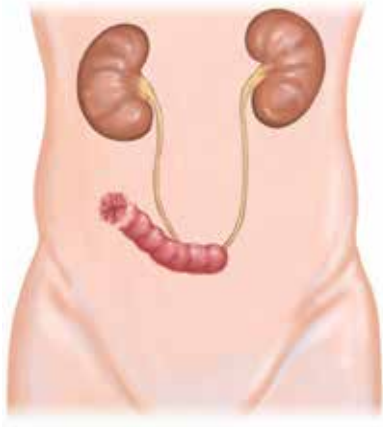
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mucous fistula) since the bypassed bowel is still live, functioning tissue.

A loop ileostomy is managed as one stoma, even though it technically has two openings. It's best to work with a knowledgeable ostomy nurse to help set up a secure



*Figure 4. A urostomy is created when the bladder is removed and a section of small intestine diverts urine from the ureters through the abdominal wall.*

pouching system, which will likely be needed for at least two to six months, after which a reversal may be considered.

## Urostomy

Of all the types of urinary diversions, the urostomy, also known as ileal conduit, has been around the longest. Developed in the 1940s by Eugene Bricker, it's also known as the Bricker ileal conduit (Figure 4). It is still the most common of the urinary diversions, as it tends to have the least complications.

Bladder cancer is the most common reason why someone undergoes an ileal conduit procedure, but there are other situations that may result in the need for one, including inflammatory conditions of the bladder (e.g., interstitial cystitis), nerve damage (e.g., spinal cord injury), and birth defects (e.g., spina bifida).

To create a urostomy, the ureters,

which normally connect the kidneys to the bladder, are detached from the bladder. The ureters are then attached to the “back portion” of the excised segment of ileum. The end of this portion is sewn shut. The other end of the ileal conduit is brought through the abdominal surface, turned back on itself (like a turtle neck sweater), and then sewn to the skin to create a stoma. The stoma will protrude a half inch or so, and is usually located on the lower right area of the abdomen.

When the bladder is removed, it is known as a cystectomy, although the bladder is not always removed when a urostomy is created. A person undergoing this surgery will always have to secure an external pouching system to collect and store urine until a convenient time to empty.

The colonic conduit is identical to the ileal version except that a segment of colon is used instead of ileum. The preferred method today is the ileal conduit, as the ileum is already located in close proximity to where it's needed and has an abundant blood supply. However, in certain situations, a colonic conduit may have certain advantages.

For example, if a person has undergone radiation treatment prior to their surgery, the ileum may also be somewhat affected (given the close proximity to the bladder). However, a segment of colon further away would be unaffected by any radiation. In addition, colonic conduits are sometimes preferred in certain pediatric cases. If you are facing a conduit procedure, be sure to discuss with your surgeon the pros and cons of the ileal versus colonic conduit.

Whether one has an ileal or colonic conduit, the tissue functions similarly to how it did when it was part of the GI tract; thus, it will continue to produce mucous.

Therefore, in addition to urine, mucous output will empty into the urostomy pouch.

Managing a urostomy may seem like a daunting task, but in time, most people adapt very well and fall into a routine that feels like no big deal. Taking care of your skin around your stoma is of paramount importance, as urine can be very irritating. Thus, pouches should be changed at the first sign of any leak to avoid skin problems.

Cleanliness is also especially important with urostomy management. If bacteria get into your pouch or stoma, they may spread to bladder, or worse, your kidneys. Simple hand washing before emptying and changing your pouch is a good practice that can help prevent infections. If you develop a high fever and/or develop discomfort in your bladder or kidney area, it's important to contact your doctor right away.

## Continent Procedures

There are a variety of surgery techniques to create continence for both intestinal and urinary diversions. These surgeries have their advantages and disadvantages compared to conventional ostomy surgeries. Each patient needs to consult a qualified, experienced surgeon when considering these complicated procedures.

Common continent intestinal diversions include the j-pouch, continent ileostomy (Kock Pouch) and Barnett Continent Internal Reservoir (BCIR). Continent urinary diversions include continent urostomies, Indiana Pouch and neobladder. See “Continent Bowel Diversions” on page 64 and “Continent Urinary Diversions” on page 68 for more detailed information. 🐾

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# Ostomy A to Z

## Getting to know the ostomy lingo

By Cliff Kalibjian

Revised by Joanna Burgess-Stocks, BSN, RN, CWOCN

If you are new to the ostomy world, it's easy to become quickly overwhelmed with new terminology when talking with your health care team or when reading about your condition. The good news is that by becoming familiar with some key terms, you will soon begin to feel much more comfortable – and fluent with the ostomy lingo around you. This article will help you get started by briefly defining various ostomy-related terms in an easy-to-understand manner.

**Adhesions** - A term your surgeon may use that refers to bands of scar tissue that normally develop after surgery. It is the body's response to healing and repairing itself. On occasion, these can cause an intestinal (bowel) obstruction. Adhesions can be surgically or medically managed if needed.

**Appliance** (ostomy pouch system, ostomy pouch, ostomy bag) - A prosthetic medical device consisting of a wafer (skin barrier) and a pouch that is worn over the stoma to contain body waste (i.e. urine, stool).

**Baseplate/Faceplate** – See Skin Barrier

**Closed-end Pouches** – Are non-drainable (cannot be emptied) and are intended to be used by those with a colostomy. For successful use, the stool should be soft to well-formed and changed on average twice a day.

**Colectomy** - A surgical procedure in which part or all of the colon is removed.

**Colostomy** – A surgical opening from the colon to the surface of the abdomen to form a stoma.

**Colostomy Irrigation** – The process of putting water into the colon through the stoma using specialized ostomy irrigation products. It is a way for a person living with a colostomy to manage and regulate their bowel movements and can result in predictable ostomy output at a scheduled time.



A skin barrier with convexity

**Continent Diversion (CD)** - A fecal (stool) or urinary diversion where control is made possible through the creation of an internal reservoir (a surgically made pouch inside your body). The reservoir is emptied by either manually inserting a catheter (small tube) into a stoma or by going to the bathroom in the “normal” way through the anus for stool, or through the urethra for urine.

**Convexity** (Convex Pouching System) – Designed for those with a flush or skin-level stoma or for those with large creases around the stoma. The convex shaped skin barrier (wafer) helps the output of stool or urine to go into the pouch instead of underneath the pouching system.

**Crohn's Disease** - A chronic inflammatory bowel disease (IBD) that can affect any part of the GI tract from the mouth to the anus but is more commonly found at the end of the small intestine (ileum).

**Diverticulosis/Diverticulitis** – A condition of the colon in which small sacs or pouches form in the wall of the colon, often people have no symptoms. Diverticulitis occurs when these small pouches become inflamed. Ruptured or perforated diverticulitis often requires the creation of a temporary colostomy or ileostomy.

**Drainable/Open Pouches** - Have an opening at the bottom through which the contents are drained. This opening is usually secured using a Velcro closure or a plastic clip.

**Flange** - The plastic round device found on a two-piece pouching system that connects the ostomy pouch to the wafer/skin barrier; found on a mechanical coupling system. The flange on the pouch and the flange on the wafer/skin barrier must match and fit together to create a secure pouching system.

**Filter** – A device incorporated into or can be attached onto a pouching system. It allows gas to be filtered out of the pouch. Filters made with charcoal allow odor to be filtered out of the pouch along with gas.

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*Ostomy Pouches. From left: a closed-end one-piece; a drainable two-piece; a one-piece urostomy pouch.*

**Folliculitis** – An inflammation of the hair follicle(s). This can occur on the skin around the stoma due to the physical trauma involved with repeatedly removing an ostomy appliance.

**Hernia** - Occurs when the intestine “bulges” through a weak area of the abdominal wall. When this happens next to an ostomy, it is called a parastomal hernia.

**Ileostomy** - The entire colon, rectum, and anus are removed or bypassed. A part of the small intestine (ileum) is brought through the abdominal wall, creating a stoma.

**Jejunostomy** - An opening created through the skin into the jejunum (part of the small intestine) that can be used for a feeding tube or as a bypass during bowel resection.

**Obstruction** – A partial or full blockage in the intestine resulting from a variety of causes including fibrous foods, cancerous growth, scar tissue/adhesions, or when the lining of the intestine is severely inflamed. This is a serious medical condition and may require hospitalization to address the cause.

**One-Piece Pouch** – The pouch and wafer/skin barrier are combined as one item and cannot be separated.

**Ostomate** – A person who has undergone surgery for a fecal (stool), urinary or continent diversion (i.e. colostomate, ileostomate, urostomate).

**Ostomy** - Surgery in which an opening (stoma) is created where urine or stool exits the body. Bodily waste is rerouted from its usual path because of malfunctioning or diseased parts of the urinary or digestive system. An ostomy can be temporary or permanent. Ileostomy, colostomy, urostomy are different types of ostomies.

**Pancaking** - When stool output collects under the wafer/barrier of a pouching system instead of going into the pouch causing leakage.

**Peristomal Skin** – The skin that is around the stoma. Having healthy peristomal skin is important for quality of life for those with ostomies. Ongoing pouch leakage can damage peristomal skin.

**Pouch Closures** – Refers to various ways to seal the bottom of a drainable ostomy pouch.

For those with a colostomy or ileostomy, they include Velcro closures that are incorporated into the pouching system or separate plastic clamps/clips that are separate from the pouching system. For urostomy pouches, the closure is referred to as a tap closure.

**Skin Barrier** – Also called a “wafer, baseplate or faceplate” is the part of the pouching system that goes against your skin and has a hole that fits around your stoma. It holds your pouch in place and should help protect the skin around your stoma from stool or urine.

**Skin Protectants** – no sting (alcohol free) barrier sprays or barrier wipes that can be applied to the skin around the stoma for those with sensitive skin. They are used to protect the skin from the adhesives used in pouching systems. They are also used to help skin irritations/sores to heal.

**Specialty Providers of Ostomy Care** – A medical professional with advanced education and /or certification to care, support and educate those with an ostomy.

**Wound, Ostomy and Continence Nursing Certification Board** – Certifies RNs with a bachelor’s degree or higher who have completed formal and experiential learning in ostomy education and who have passed a certification exam(s).

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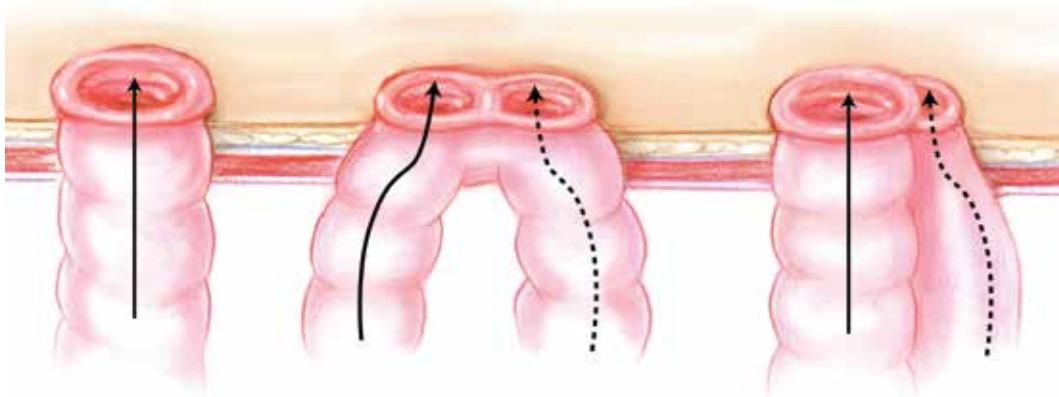
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*Types of stomas: Left, end stoma; Middle, loop stoma; Right, end-loop stoma.*

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**Wound Care Education Institute (WCEI)** – Offers certification prep courses including a one-week educational program for Ostomy Management Specialists (OMS).

- Candidates who complete this program can sit for the examination offered by the National Alliance of Wound Care and Ostomy Member Association (NAWCO).
- Recertification is every five years and can be done through an online or onsite refresher course.

**Stoma** - A portion of the large or small intestine that has been brought through the surface of the abdomen (belly) and then folded back like a sock cuff. A stoma provides an alternative path for urine (in the case of a urostomy) or stool (in the case of a colostomy or ileostomy) to leave the body.

**Stoma Blockage** - When something obstructs the stoma preventing stool from coming out. blockage can be partial (a small amount of stool is able to come out) or complete (no stool is able to come out).

**Stoma that is Flush**- A stoma that is at the same level with the surface of the skin. This may result in pouch leakage and skin irritation.

**Stoma Measuring Guide** – A card with special holes used to measure the stoma. This is useful when selecting the correct wafer/skin barrier size for your pouching system, when ordering samples, or when using it as a template to cut out the stoma opening on your wafer/skin barrier.

**Stoma Prolapse** – The telescoping (protrusion) of the intestine through the stoma which makes the stoma appear much longer than “normal.” Your surgeon should be notified if this happens.

**Stoma Retraction** – A stoma that has receded to the level below the surface of the skin. This may result in pouch leakage and skin irritation.

**Two-Piece Pouching System** - The pouch and wafer/skin barrier are separate from each other and must be attached through either a mechanical, adhesive or interlocking coupling system. The pouch can be removed to be changed or emptied without removing the wafer/skin barrier.

**Ulcerative Colitis** – A form of inflammatory bowel disease that targets the colon (large intestine) and affects its innermost lining. Symptoms can include abdominal pain, fatigue, weight loss, and bloody diarrhea. Surgery for this condition may result in one having an ostomy.

**United Ostomy Associations of America (UOAA)** – A national non-profit organization that promotes quality of life for people living with ostomies and continent diversions through information, support, advocacy and collaboration. UOAA also supports and connects people to over 300 affiliated support groups (ASG) across the country. Please contact them at 800-826-0826 or visit [www.ostomy.org](http://www.ostomy.org).

**Urostomy (Ileal conduit)** – A type of ostomy surgery in which a passageway for urine (conduit) is made by attaching the ureters to an isolated piece of the small intestine (ileum) which is brought outside of the abdomen to form a stoma.

**Wafer** – See Skin Barrier

**Wear Time** – Refers to the length of time an ostomate can wear a pouching system before leakage occurs. This is individualized and will depend on the product and body contour.

**ZZZZ** – Get some rest now!!

Many ostomy-related terms are defined above, but there will always be more. Whether you are new to the ostomy world or experienced with it, you will be continuously learning. By working with your health care team and arming yourself with the right knowledge, you will learn the best ways to take care of yourself. For more information, go to [www.ostomy.org](http://www.ostomy.org), call 800-826-0826 or see a qualified ostomy nurse. 🍷





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# A Successful Recovery

## Tips and strategies for coming back strong after surgery

By Diana Gallagher, MS, RN, CWOCN, CFCN  
Facilitator for the NWA Ostomy Support Group

For many, ostomy surgery is lifesaving, but initial feelings can sometimes be negative. For individuals with years of unresolved incontinence or inflammatory bowel disease, however, life after surgery is frequently viewed as a positive improvement and the promise of a return to a normal life.

The following are important tips to help you transition into your new life and embrace living with an ostomy. For more information visit [www.ostomy.org](http://www.ostomy.org) or contact United Ostomy Associations of America at 1-800-826-0826.

1. Select a surgeon with valuable experience in the type of surgery that you are facing. General surgeons as well as specialty surgeons can perform ostomy surgery. Specialty surgeons are those who have completed additional education, training, and fellowships within the specialty. These surgeons will be identified as Colorectal or Urology Surgeons. You can find a local physician through the websites for the American Society of Colon and Rectal Surgeons or American Urological Association.

2. See an ostomy nurse. Before surgery, your surgeon may refer you to a specialty nurse, like a Certified Wound Ostomy and Continence Nurse (CWOCN). If not, you can call your local hospital, wound/ostomy clinic or local support group for assistance in locating an ostomy nurse. This nurse will help ease your transition into living with an ostomy.

Your ostomy specialist will provide comprehensive education including practice pouch changes before surgery. In addition, he/she will identify and mark the best location for your ostomy. During surgery, it is difficult for your surgeon to know where the waistband of your pants sits, where creases or irregularities exist and other special considerations to consider when selecting the optimal site.

3. Attend a UOAA Affiliated Support Group (ASG) meeting in your community. You may think that you do



not need a support group or not feel comfortable in a group setting. Put those feelings aside; listening in the beginning is a good start. Join your local group, even if you don't initially find someone your age with a similar story, there is a lot to learn. UOAA affiliated support groups are truly one of the BEST places to obtain the necessary education, helpful hints, support, and resources. Don't feel that you are alone.

4. Determine which supplies will work best for you. In the beginning, you will most likely receive sample products from a number of companies. It is helpful to keep the 2 piece products from each manufacturer separated; wafers from one company will not necessarily snap onto a pouch from another company. The sampling program will help you try a variety of products to learn which ones work best for you.

5. Order your regular supplies. Once you know what you like best, an order can be placed through a distributor. There are countless distributors from which to choose from and depending on insurance, your supplies can be delivered monthly or every three months. The first time that you order, it is logical to order a month's worth of supplies. As your expertise develops, you may fine-tune your list. Insurance normally pays 80% of supplies that are medically appropriate. If you have a secondary

plan, the remaining 20% may be covered. Check for a list of the limits for each product. Reorder supplies early so that you are never without what you need.

6. Select a place to keep your ostomy supplies organized. Many people keep their basic supplies in a bathroom drawer, others buy a plastic organizer with several drawers that can be moved about. Excess supplies can be stored in a closet but regardless of where you choose to keep supplies, it is best to avoid temperature extremes and high levels of humidity.

7. Be prepared. In addition to the extra supplies that you keep on hand at home, always keep a small pouch with all the supplies necessary for a complete change with you. Like your other supplies, these should be kept away from temperature extremes and humidity. Hopefully, you will rarely need to make an unplanned change, but being prepared, makes most ostomates feel secure and confident. If you anticipate an occasional return to the hospital, keep a bag packed with your preferred supplies. The hospital may not have the brands that work best for you.

8. Promptly consult your ostomy specialist for any problems. This might be a decrease in normal wear time, a change in your stoma, or a problem with your peristomal skin. A good practice for all is to hydrate

properly to avoid complications.

9. Recover from surgery and LIVE life to the fullest. Having an ostomy does not change who you are or what you are able to do. After recovery, work to strengthen your abdominal muscles to help prevent hernia risk and enjoy all your old activities including swimming. Every October UOAA holds the Run for Resilience Ostomy 5k where people of all ages prove that living with an ostomy does not need to be limiting. Visit [www.ostomy5k.org](http://www.ostomy5k.org) for more information.

10. Advocate for yourself. You will find that not everyone is knowledgeable about ostomies. Educate others when possible, but always be willing to advocate for yourself and others. You can also help by supporting UOAA's advocacy program and taking part in events like Ostomy Awareness Day held on the first Saturday in October. UOAA works toward a society where people with ostomies and intestinal or urinary diversions are universally accepted and supported socially, economically, medically, and psychologically.

11. Tell your story. Your story has the power to help others as they begin their journey. Connect with others at a support group meeting, online or contact The Phoenix ostomy magazine ([www.phoenixuoa.org](http://www.phoenixuoa.org)) to help the next person who has this lifesaving surgery. 🙋

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# Ostomy Reversals

By David E. Beck, MD, FACS, FASCRS  
Clinical Professor of Surgery at Vanderbilt University

The majority of stomas currently created are temporary and created with the intention of reversal at a future date. This article describes the creation and characteristics of temporary stomas.

## Types of Ostomies

There are several types of ostomies: loop, end, and end loop (Figure 1). In an end stoma, the end of the bowel is brought through the abdominal wall and the stoma has a single lumen or opening. A loop stoma as described below has two openings.

An end stoma is usually created when a section of bowel has been removed. The other end of the bowel may be absent or left in the abdomen as a Hartman's (closed off rectum). It may also be brought through the abdominal wall and connected to the skin. There will be no intestinal contents coming out, just mucous. That is why it is often called mucous fistulas.

Temporary stomas are more often loop type stomas. A loop stoma is generally easier to create. With a loop stoma, there are two openings. This type of stoma diverts the intestinal contents away from the distal bowel. Loop stomas are usually easier to close as both ends of the bowel are juxtaposed. The indications for a temporary stoma include distal obstructions (tumors, inflammatory disease [diverticulitis or Crohn's disease]), leaks or fistulas, or to protect an anastomosis (j-pouches or low anterior resections).

A variation of a loop stoma is an end loop stoma. In this type of stoma the distal end of the loop has been closed off. This completely diverts the bowel contents and is used when a short mesentery (the fatty layer through which the blood vessels pass to the bowel) makes it difficult for the bowel to reach the skin.

Even though the stoma is planned to be temporary, some will become permanent. This may happen if their disease progresses, other conditions develop or worsen (strokes, heart disease, etc) or the patient decides that they are happy with their stoma and/or don't want to go through another operation. For these reasons and to minimize any problems while they have a stoma it is very important to have the stoma correctly created (i.e. good location and adequate bowel protrusion).

## Stoma Location

It is best to pick the location of the stoma prior to surgery. A portion of the abdominal wall is selected that is relatively flat and away from bony prominences, scars and folds of fat and skin. It is important that the patient can see the location. It is important to evaluate the proposed location with the patient standing and sitting as skin folds may be present in different positions. The assistance of an ostomy nurse in selecting stoma locations is often helpful. The opening through the abdominal wall must be adequate size to allow the bowel and its accompanying blood vessels to pass through without constriction.

A certain amount of bowel protrusion is desired. The amount will depend on the type of stoma and whether there is not too much stretch on the bowel and its mesentery. A protrusion of 2-3 cm is preferred for ileostomies and 0.5 – 1 cm for colostomies. The bowel is

then folded back on itself and attached to the skin with several absorbable sutures. This is referred to as stomal maturation. The edge of bowel mucosa is sutured to the skin dermal layer.

To maintain the desired protrusion, the bowel wall is sutured to the subcutaneous fat or the maturation suture also includes part of the bowel wall. Close approximation of the mucosa to the skin hastens healing. If there is a lot of tension of the bowel (which wants to pull the bowel back into the abdomen), surgeons will often use a plastic rod to help support the loop stoma.

## Special Circumstances

A number of patient characteristics can make stoma creation challenging. One of the more common of these is obesity. Excess fat is deposited in the abdominal wall and bowel mesentery. The fat mesentery is often shorter which makes it harder to reach above the abdominal wall and requires a larger hole in the abdominal wall to allow the bowel to pass through the abdominal wall. The subcutaneous fat makes it a larger distance the bowel has to pass to reach the skin.

Losing weight prior to a planned surgery can help, but it is often difficult or impossible. Another option is abdominal wall modification or countering. Diseased bowel (radiated or involved with Crohn's disease) is also difficult to manipulate. It is preferred to use bowel that is soft and pliable.

***“The time from creation of a temporary ostomy to closure will vary from six weeks to six months and depend on several factors.”***

## Stoma Closure or Ostomy Reversal

When the stoma is no longer needed, it can be reversed. The time from creation of a temporary ostomy to closure will vary from six weeks to six months. The shorter period allows the patient to recover from their previous surgery and time for the stoma to mature and scar tissue to soften making the subsequent operation easier. The time chosen will vary among surgeons and on the patient and their disease process.

If the initial surgery was hard or there was significant infection or inflammation, a longer recovery time is preferred. If the patient needs chemotherapy, some surgeons prefer to wait until the patient's chemotherapy is completed before the stoma is closed. Others (including the author) prefer to close the stoma before the chemotherapy is given.

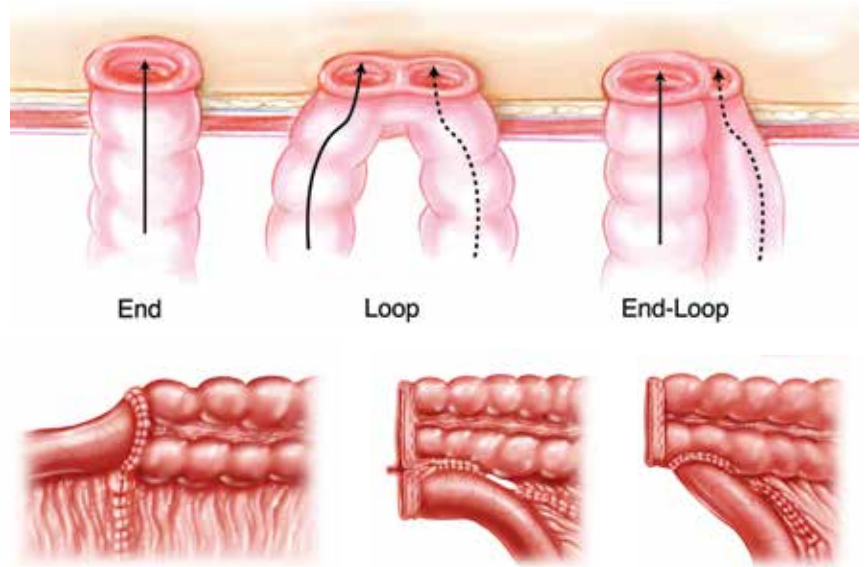
Reversal of a loop stoma is usually referred to as a stomal closure, while reversal of an end stoma is often referred to as a stomal takedown. A stomal closure is usually a much smaller operation. As both ends of the bowel are attached to the skin, the surgeon only needs to detach the bowel mucosa from the skin (using a scalpel or electrocautery) and divide any adhesions of the bowel surface to the subcutaneous fat and abdominal wall muscles.

This is usually done with scissors or electrocautery. Once the bowel limbs are freed up, the bowel can be pulled above the abdomen. The ends of the bowel can now be connected to form an anastomosis. This can be done with staples or sutures. The different types of anastomosis are described in Figure 2.

Most surgeons use a side-to-side function, end-to-end type when they close a loop stoma. The reconnected bowel is then dropped back into the abdomen and the muscles of the ostomy site are closed with sutures. The skin and subcutaneous tissue can then be left open, partially closed or closed with sutures or staples. The author prefers to partially close the skin. This reduces the time required to heal and lessens the chance of infection. The operation usually takes less than an hour.

## Post Operative Function

After surgery, the patient's bowel will be slow to function, which is a condition called ileus. After stomal closures, ileus is usually shorter than after a takedown. Most patients will be started on liquids the evening of or the day after surgery. With modern perioperative care the hospital stay is one to three days



Top: Figure 1; Types of fecal stomas.

Bottom: Figure 2; Types of bowel anastomosis.

A stomal takedown is a bigger operation. As the distal end of the bowel is inside the abdomen, an incision is required to gain exposure. Usually, the previous midline incision is opened. Knowing which piece of bowel will be used will help guide whether all or part of the previous incision will be needed. If the distal bowel is a Hartman pouch (closed rectum) the lower part of the incision is used. If the distal bowel is the transverse colon, the upper portion of the wound is used.

Once the muscles of the abdomen are opened, adhesions are divided and the distal bowel is located and mobilized. The end stoma is then detached from the abdominal wall as described in the section on loop stomas. The two ends of the bowel are then brought together and an anastomosis is performed. The major incision and the old stoma site are closed with sutures.

After a stomal takedown the postoperative ileus is about the same as after a bowel resection. Most patients will be started on liquids the evening of or the day after surgery. The hospital stay after a stomal takedown is usually three-to-five days.

There are risks associated with any surgery including a stomal closure. These include bleeding, infection and leakage from the bowel. Fortunately, these are uncommon. The patient's bowel function after stomal reversal will depend upon how much bowel remains usable. If most of the bowel remains, the bowel function will be near normal. The more bowel that has been removed, the more frequent and loose the bowel movements will be. Fortunately, the remaining bowel can take over some of the function of the lost bowel. ☞

# Peristomal Hernias

## Understanding this possible complication of ostomy surgery

By David E. Beck, MD, FACS,  
FASCRS  
Clinical Professor of Surgery  
at Vanderbilt University

This article will discuss abdominal hernias with some emphasis on peristomal hernias. A hernia is defined as the abnormal protrusion of an organ or other body structure through a defect or natural opening in a covering membrane or muscle. The defect can occur in many locations such as an incision, on the groin or around a stoma (peristomal hernia).

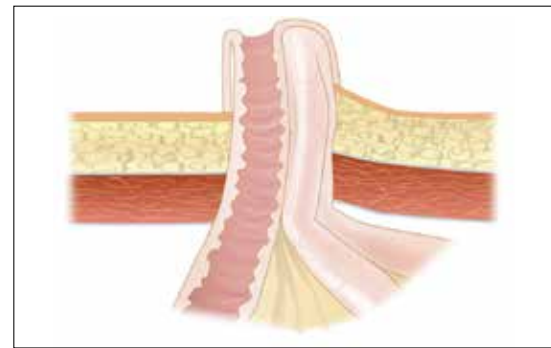
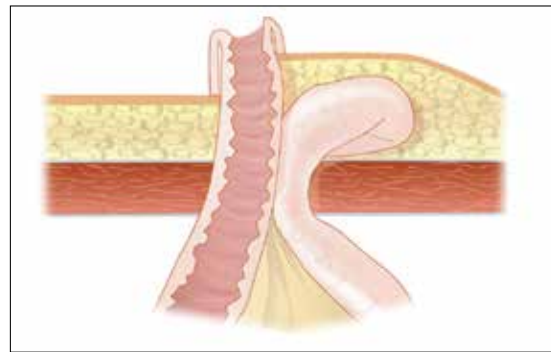
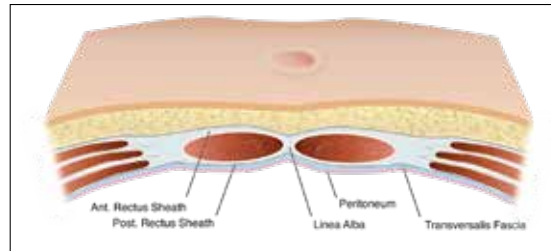
To improve patient understanding, we will first review the abdominal wall anatomy, then discuss various types of hernias, the symptoms they produce and methods of repair.

### Anatomy

The abdominal cavity is surrounded by the abdominal wall. This wall is composed of several layers (figure 1). The layers are composed of different material that have varying strengths. The inner layer is the peritoneum. Next are various layers of tissues called fascia and muscle. Outside of the fascia is a layer of subcutaneous fat which is covered by skin.

The fascia and muscle have the greatest strength. The various layers also contain many structures such as nerves, lymphatics and blood vessels. These structures vary in size and location. Some remain within a layer and others pass through the layers. The construction of the layers and structures that pass through them produce areas of potential weakness. Hernias are more common in these sites.

Other factors that may lead to hernias: the failure of a portion of the abdominal wall to develop correctly;



From top. Fig 1. Cross section of abdominal cavity. Fig 2, 3. Common peristomal hernias

weakness due to forces associated with activity of living; infections; tumors; or the trauma associated with surgery. Opening the abdominal wall (eg. cutting or dividing skin, muscles and fascia) to perform an operation, creates a potential weak spot; especially if the area does not heal properly.

Factors that hinder healing include infection, malignancies, improper closure technique (sutures placed too far apart, tied too tight, too much tension, or inadequate blood supply), and patient factors (obesity, steroid use, tissue ischemia, COPD), previous surgeries, placement of a stoma or drain tube.

### Symptoms

Hernias are relatively common. Some are small and cause no symptoms. Hernias tend to increase with time and when they enlarge they may produce a bulge which is aesthetically displeasing. Some will produce a dull pain from stretching of tissue. If a piece of bowel becomes trapped in the hernia it may produce a bowel obstruction (crampy abdominal pain, nausea, vomiting, etc). If the bowel can gently be pushed out of the hernia it is referred to as reducible. This may relieve the obstruction. If the bowel or organ remains trapped in the hernia it is called unreducible or incarcerated. If the bowel in the hernia twists or becomes swollen the blood supply to the bowel may be compromised and it may become ischemic or die. This will lead to an infection, obstruction, perforation, or, if untreated, death.

Most hernias are apparent when the patient is examined. Often they are apparent when the patient is standing. If there is a question (especially in obese patients or those with a lot of scar tissue) a CT scan

can identify a hernia and document if it contains bowel or other organs. Some hernias can be managed with a support belt.

The decision to repair a hernia must take into account the patient's symptoms, benefit(s) from surgery and risks from surgery: infection, injury to bowel, bleeding, the cost and discomfort associated with surgery, and the chance the hernia could recur. If the hernia is small and asymptomatic, many would choose to just observe it.

As mentioned previously, hernias can occur in several locations. The more common types include peristomal, incisional, and inguinal (groin) hernias.

### **Peristomal Hernia**

Enlargement of the abdominal wall opening that contains a stoma results in a peristomal hernia (fascial defect). This hernia provides a potential for other loops of bowel to get trapped (Figures 2, 3). The incidence of hernias at the stoma site (peristomal hernia) has been described to occur in zero to 48.1% of patients. Efforts to lower the incidence of hernias include siting the stoma within the rectus muscle, making the correct size of the abdominal aperture, and the use of prophylactic mesh at various levels in the abdominal wall, extraperitoneal tunneling of the stoma and fixation of the stoma to the abdominal fascia.

The prophylactic use of mesh around the stoma has reduced the incidence of peristomal hernias, but has the potential to produce stomal stenosis, erosion, or infections. These complications are lessened if a biologic mesh (modified pig skin or bovine pericardium) is used.

### **Incisional Hernias**

Hernias at incisions produce a bulge and have the potential for bowel to become trapped. The incidence of developing a hernia with an incision has been described at <1 to 20%. Most develop in the first two years of the original operation. The chance of developing a hernia increases for the reasons described previously (infection, technique, patient factors).

### **Groin Hernias**

Groin (inguinal or femoral) hernias are very common. Repairing these hernias is one of the most common operations done by general surgeons. Groin hernias occur more frequently in men as the spermatic cord and testicular vessels pass through the lower abdominal wall to the testicles in the scrotum. This opening is a potential weak area.

### **Methods of Repair**

There are several ways to repair hernias. The method chosen will depend on the size and location of the hernia defect and the experience of the surgeon. The first option is known as primary repair where the hernia is opened and the muscles and fascia are sutured back together. This is the simplest method of repair and is usually chosen for smaller hernias that are being repaired for the first time.

For larger incisional hernias, many surgeons now use a component separation technique. This method involves cutting some of the muscle layers laterally to allow the other muscles and fascia to slide toward the midline and close the hernia defect with less tension. As the chance of recurrence is higher with either of these two techniques, many surgeons will reinforce their repairs with the addition of artificial material.

The first type of reinforcing material available was made from synthetic material (polypropylene, polycolonic, plastic, etc). Some of these are permanent and some are absorbable. Most were made in a mesh pattern to allow tissue to grow into the material. The ingrowth of material improves strength and reduces the chance of infection. The use of any foreign materials does lead to a higher chance of infection.

Peristomal hernias deserve additional comment as the bowel goes through the defect which maintains a potential area for weakness. Repair options for peristomal hernia include direct local tissue repair, resiting of the intestinal stoma with closure of the primary aperture and the application of mesh around the stoma at various levels within the abdominal wall. Surgical wound infection was more common when mesh repair was used and recurrent hernias were much more common with direct fascial repair.

All of the operations described to repair peristomal hernias can be applied to patients with stomal prolapse, retraction and skin irritation associated with a flush ileostomy. In addition, for patients with prolapse, local amputation and re-anastomosis can be used, often with low morbidity. The best operation to perform in individuals having significant stomal complications is closure of the stoma and restoration of intestinal continuity. However, this is not always possible

### **Conclusions**

Hernias are defects in the abdominal wall and are, unfortunately, very common. When they become large or symptomatic, surgical repair should be considered. Newer techniques have produced improved results. 🐾

***“Hernias are relatively common and tend to increase with time. They may produce a bulge which is aesthetically displeasing.”***

# Peristomal Skin Care

## Tips and techniques for adhering a pouch over red and moist skin

By Joan Junkin, MSN,  
APRN-CNS, CWOCA

Crusts are good for more than keeping bread fresh! Making a “crust” around your stoma can provide a better seal, especially if your skin is red and a bit moist. The crust involves a special powder and liquid skin barrier. It is simple to do and a skill that is handy to have in case you ever have a rash, sore or red area near your stoma that makes it hard to get a pouch wafer to stick very well.



Photo courtesy of Hollister Incorporated.

### First Step

Consider consulting your ostomy nurse if you are not confident about stoma care yet. It is possible that the skin contours near the stoma have changed and you may need a different type of wafer. If you are experienced and know what changes to watch for and what to do about it, please read on.

However, even if you are experienced and you notice that your solutions are not working, please contact your ostomy nurse for a second opinion. Many nurses do not have a stoma, yet we have been taught what to watch for and how to deal with most situations. The best way we have learned is from people who do have a stoma! That's the favorite part of an ostomy nurse's job – to see your great problem solving techniques and then pass them on to others!

### Moist Skin

When skin gets sore or red it often oozes a bit of moisture. That is what prevents the wafer from sealing well. If the wafer seal is not good, stool or urine causes more soreness and a vicious cycle can occur! In this situation, there are two techniques that can help. The first method costs more, so if your insurance will not pay for the product discussed, or you don't mind trying the second method, you might consider that instead.

The first method involves using an ostomy ring or strip over the moist area. There are many from which

to choose from including Coloplast, ConvaTec, Genairex, Hollister and Marlen. These are all a putty type material, a lot like clay. You can squish it and form it to whatever you need. It helps to take a piece of it, flatten it between your fingers and place it directly over the red area. This material is able to soak up the moisture so you can keep a better seal. You may also

try adding a ring of the material all the way around the stoma. Think of caulking a window so wind doesn't get in, only this time we're trying to keep something from leaking out instead!

### Crusting

The second method takes a bit more time, but is also quite effective and usually costs less. It is called 'crusting.' Crusting involves lightly covering the sore or red area with a powder, moistening the powder, letting it dry, then repeating the process a couple more times. Which powder you use depends on the type of rash or sore you have. If the rash is spotty (see photo) it may be a fungus, like heat rash.

This is especially likely if the rash area is also itchy. These rashes are quite common, especially when it is hot and humid or if your skin around the stoma tends to get sweaty often.

For a spotty rash suspected to be fungus you may want to speak with your ostomy nurse or doctor, especially if this is the first time you've gotten it or it's not getting better within a week. Crusting for a spotty rash like fungus involves getting an antifungal powder – there are many non-prescription products available. It will say 'anti-fungal' on the package.

After discussing this with your ostomy nurse or doctor, gently cleanse the area by soaking it for a few minutes with warm water. It is not recommended to use soap since most soaps are alkaline and fungus actually thrives on alkaline skin.



## Skin Barrier

After cleaning the area around the stoma gently, let it dry well. A hair dryer on a cool setting may be useful. Then, lightly dust the rash area with the anti-fungal powder and moisten the powder with a liquid skin barrier. Most liquid skin barriers contain alcohol,



although you can find “no sting” barriers without alcohol. It is preferred to use the non-alcohol type when you have a rash or sore because regular ‘skin prep’

with alcohol will sting and is harsh on the injured skin.

Apply the non-alcohol liquid skin barrier by either spraying it over the powder or gently pat the powder with the wipe or swab containing the liquid. After you have moistened the powder, allow it to dry. You will know it is dry when the color lightens. When dry, lightly dust the area again with more powder and moisten that layer of powder the same way. Many people add a third layer of powder moistened with liquid skin barrier.

For a red area or sore near the stoma that does not look like a fungal rash, you can use the same process as above, but use an ostomy powder instead of anti-fungal powder. There are many ostomy powders, some contain pectin, others contain karaya. These powders absorb a little bit of moisture and get sticky when moist.

You can also use pectin powder which is similar. The process is the same: lightly dust with the ostomy powder, moisten it with a non-alcohol liquid skin barrier, let it dry and repeat once or twice. This process takes just a few minutes after you become comfortable doing it. You might want to try it on easy-to-access skin first before trying it on the tender skin near your stoma.

This process, known as ‘crusting’, provides a layer of powder/dried barrier that can absorb a bit of moisture from the sore skin so you can maintain your seal. Remember, neither of these methods, crusting or using an ostomy ring or strip takes the place of a properly fitting appliance. It is always important to make sure the hole in the wafer is the right size and that the appliance is fitting into any contours of your belly. If the appliance doesn’t fit well there is no amount of crusting that will help. In that case, it is important to seek help from an expert such as a certified ostomy nurse.☺

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# One-Piece vs Two-Piece

(adapted from Pouching Systems Patient Educational Sheet)

One-Piece	Two-Piece	Two-Piece Adhesive Coupling
Barrier and pouch are one unit	Barrier and pouch are two units	Barrier and pouch are two units
		
Minimal hand strength and dexterity needed	Some hand strength and dexterity is needed	Minimal hand strength and dexterity needed
Fewer steps are required as the pouch and barrier are already attached	May be easier to apply as you can see the stoma during application	May be easier to apply as you can see the stoma during application
Lower profile may be less noticeable under clothing and is flexible	The pouch can be changed more frequently than the barrier	The pouch can be changed more frequently than the barrier and is flexible and less noticeable
Unless you remove the entire system, you will be unable to: * Readjust your pouch * Interchange between various types of pouches	You can interchange the type and/or size of the pouch (drainable/closed-end, etc.) without removing the barrier	You can interchange the type and/or size of the pouch (drainable/closed-end, etc.) without removing the barrier
The barrier is flexible (no rigid plastic ring). Flexibility may be needed for uneven abdomens and more comfortable	The barrier is less flexible Less flexibility may help support loose skin around the stoma	The barrier is flexible (no rigid plastic ring). Flexibility may be needed for uneven abdomens and more comfortable
Offers a lower profile than the standard two-piece system A drainable pouch or closed-end pouch is available	The two-piece system can be "burped" to let the gas out from the pouch by briefly releasing a small section of the pouch from the barrier	Offers a lower profile than the standard two-piece system The two-piece adhesive coupling system can be "burped" to let the gas out from the pouch
This may be an option for the school age child or adolescent who is more aware of "body image" and visibility of their pouch under their clothing- Consider for under a bathing suit or other tight fitting clothes where discretion is the main concern.	Consider in infants or children who experience a lot of gas	Consider in infants or children who experience a lot of gas This may be an option for the school age child or adolescent who is more aware of "body image" and visibility of their pouch under their clothing

Product photos courtesy of Coloplast



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Medicare Approved - Patents: US 781,5618 - US 784,2018 - D607,559 S - 618,791S - Other patents pending

# Five Reasons Pouches Leak

## Using PSI - Pouch Scene Investigation - to find the source of a leak

By Anita Prinz, RN, MSN, CWOCN

Ostomy leaks can be extremely distressing, cause anxiety and contribute to a poor quality of life. To prevent leaks, it is critical that you understand why your pouch leaks as well as how to fix the source problem. Maintaining a well-fitted pouching system will ensure you have the opportunity to resume your life style.

Modern ostomy pouches wear out, erode and eventually will leak if not changed in a timely manner. Everyone's ostomy wear time is different – every day, every three days and even every seven days. What's important is that you change your pouch before it leaks and don't get caught off-guard.

### Ostomy Management

Generally, ostomy pouches leak from the inside-out, not the outside-in. So no matter how much you tape your barrier, if it's leaking the tape will not stop it – it will only buy you some time. The longer the effluent sits on your skin, the greater the risk of skin erosion, fungal rashes, bacterial infections, cellulitis and embarrassment. A pouch may leak from the outside in when swimming, bathing or from a draining wound – this is when the pink tape is helpful.

When you change your pouch, always look at the back of your barrier to determine if you have had any effluent leaking or areas where the barrier has eroded due to effluent. It should be essentially dry with perhaps some swelling around the hole for the stoma. Extended wear barriers on urostomies tend to really puff out or "turtleneck" around the stoma as seen from the outside, but on the inside of the barrier it should be dry. When you remove your ostomy pouch, your skin should look just as clean and healthy as it did when you applied it.

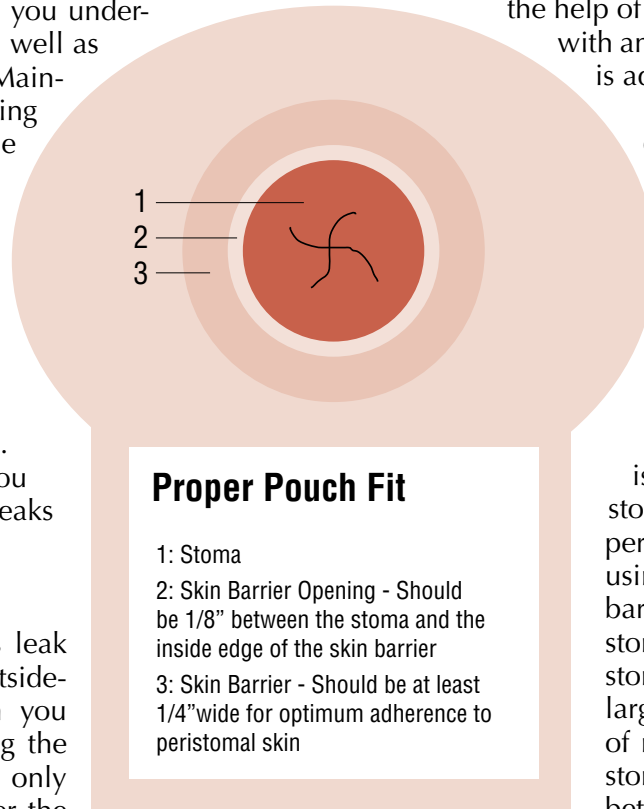
The following are five common causes of pouch leakage. This list is not all inclusive and is not in any

particular order, except perhaps most difficult to manage to easiest. Another cause of leakage is a poorly sited stoma or poor stoma construction. In these cases, the help of an ostomy nurse or consultation with an experienced colorectal surgeon is advised.

You must be a little bit of a detective to figure out why you are having leaks and hopefully this information will help you with your "pouch scene investigation" work.

### 1. Poorly fitting pouch

The barrier opening or hole should be no more than 1/8" larger than the stoma. It is important to measure your stoma for the first few months and periodically to ensure that you are using the right size opening. The barrier should be snug up to the stoma edge, but not touching the stoma. Be sure your skin barrier is large enough to provide at least 1/4" of material all the way around the stoma to adhere to your skin. It is better to size up than to size down.



### 2. Peristomal Skin Lesions

Leaks can lead to compromised skin integrity which can be very painful. Often, the denuded skin is similar to a broken blister and when stool touches it, the pain can be quite excruciating. Weeping, denuded skin leads to a vicious cycle of leaking pouches, increased use of supplies, treatment medications, doctor visits and your time and money.

Irritant dermatitis, fungal rashes, psoriasis, pyoderma, and pseudoverrucous lesions are the most common culprits of peristomal skin lesions. If your skin looks like a raw tomato and is weeping, you are probably having trouble keeping your pouch on. Treatment of peristomal lesions is imperative to obtaining a good seal. While your skin is under treatment, wear time may be less, but once your skin has healed it should return to normal.

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### 3. Body Changes: Creases, Wrinkles, Hernias

If an individual is overweight, skin folds and creases in the peristomal skin increase the potential for leakage. If you have had recent weight loss or weight gain, then your stoma and/or the contours of your abdomen may have changed as well. Measure your stoma periodically to ensure correct sizing.

Assess your stoma and the surrounding skin without wearing a pouch or skin barrier while standing, lying down, bending over and, most importantly, sitting down. Creases are most prominent or noticeable when sitting, make sure you use a mirror or have someone help you. Creases need to be filled to ensure a flat landing area for the barrier to make an effective seal. Products to use include skin barrier strips, Cohesive® seals, skin barrier washers and rings that can be cut or molded into a variety of shapes and sizes.

Pastes can also be used to fill in or caulk creases or make a “gasket” around the stomal opening, but do not help adherence and are generally not effective for urine. If caulking doesn’t work, then try a convex pouch. If convexity doesn’t work, use convexity with caulking. Your goal should be to get about four days wear time, but again, everyone is different. At the minimum, a drainable pouch should last 24 hours.

One-piece pouches are more flexible and bend easily while a two-piece pouch is stiffer and may buckle and pop off when you bend or sit. If your stoma has retracted or sunk in, then you may need to use a convex pouch with a belt. The convexity will help push your stoma out and also flattens creases. Sagging or fluffy skin above the stoma needs to be pulled up and flattened out when applying the pouch.

### 4. Wrong Pouch

Liquid output from ileostomies and urostomies requires an extended-wear barrier to absorb more moisture. Liquid stool or urine erodes the barrier much faster than formed stool. When these products erode, you will notice a white puff or “turtleneck” around the stoma opening – this is completely normal.

All manufacturers make an extended-wear pouch but, unfortunately, they each call it something different. Look for extended wear in your descriptions or call the manufacturer. Note that extended wear pouches can be harsher on your skin and are not intended to be changed on a daily basis.

### 5. Improper Application

One of the greatest causes of poor pouch adherence

is improper or incomplete skin preparation and poor application technique. Here are some basic tips.

Stop eating or drinking for an hour before you change your pouch; no fun changing a busy stoma.

Rinse soaps and adhesive removers off thoroughly; this can impede adherence.

Trim peristomal hair – it impedes adherence!

Dry your skin thoroughly. Moist skin will interfere with adhesion. Many people actually blow dry their skin to ensure that it is completely dry.

Use a mirror or have someone help you if you cannot see your stoma. If you can’t see it you are more likely to inadvertently apply the barrier on top of the stoma rather than around it.

Empty your pouch in a timely manner, when it is 1/3 to 1/2 full. If you know your pouch leaks on day four, get in the habit of changing it on day three.

Press the pouch firmly enough around the stoma to adhere to the skin.

Consider a pouch with a built in-vent to release flatus – or release gas as needed.

Don’t use multiple products; if you are using more than three products under your barrier you are probably using too many. Keep it simple.

Don’t wear gloves when changing your pouch; you won’t be able to feel if your skin is dry.

Don’t wear pants tight around the pouch so that it can’t drain properly.

### Conclusion

Currently there is no research on the evidence of why ostomy pouches leak and/or which is more common than another. This article is based on my 14 years of experience as a Certified Wound Ostomy Continence Nurse. Obtaining a good seal and knowing your wear time will provide you with a sense of security and give you the confidence to go about your life. Keeping a calendar with the days you change your pouch may be helpful to learn your wear time.

Take notice if your wear time is less in hot weather or if you are exercising more. Supplies that are above the insurance limits can be approved with a letter of medical necessity from your physician. Become pro-active and always change your pouch before it leaks. If you are not able to get a good fit or seal, contact your local Affiliated Support Group or the manufacturer of your pouching system or your local Wound Ostomy Continence (WOC) nurse or a for their expertise and assistance: [www.wocn.org](http://www.wocn.org). ☂

***“Without a pouch or skin barrier on, assess your stoma and the surrounding skin while standing, lying, bending over and, most importantly, sitting down.”***

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# Peristomal Skin Products

## Understanding when, why and how to use ostomy skin products

By Joy Boarini, MSN, WOC Nurse

The pouching system you use is critical to living successfully with an ostomy. In addition, you may be using one or more ostomy accessories. However, it is not uncommon that some people do not understand what the intended purpose of a particular accessory is. They may even be using it incorrectly. This can impact wear time, and skin health. You may be someone who does not currently use accessories, but may find that you could benefit by adding them to your routine care.

### Accessory Uses

Hospital stays are becoming shorter and shorter, lessening the time allowed for clinicians to educate their patients on product options. Many people use the same products they were given in the hospital — even though their stoma, skin, output, and activity have changed. Adapting your products so that they work for you is key to successful ostomy care.

There are many reasons why a peristomal skin accessory might be recommended. It may be used to help enhance the performance of a pouching system. For example, it may help increase wear time, prevent skin stripping, or make adhesive removal easier. Also, an accessory may help solve a problem like leakage or skin irritation. Whatever the reason, it is important to remember that there should be some benefit to using it. If there is not, you may want to reconsider why you are using it at all.

### Available Accessories

Flat barrier rings are used primarily to protect the peristomal skin, and to help prevent leakage under the barrier on a pouching system. Barrier rings have become a popular alternative to skin barrier paste. They are sometimes easier to handle, are alcohol-free, and may enhance wear time. Barrier rings can be used to create oval and customized openings if cutting is a challenge.

To use a barrier ring, remove the protective backing from both sides of the ring before use. To meet your

needs, the ring can be stretched to create different shapes and sizes. Some rings are extended wear and some are standard wear skin barriers.

Although the ring can be applied directly to the skin, it is usually best applied to the back of the pouching system prior to application. This makes it easier to

control the placement, especially if you are still gaining experience with your pouch change procedure.

Convex barrier rings help to protect peristomal skin,

create a secure seal, and help prevent leakage under the barrier on a pouching system. These unique rings can be used to create oval convexity, deeper convexity, or flexible convexity. Round and oval convex rings in a variety of sizes are available.

To use this accessory, you need to remove the protective backing from both sides of the ring. Like flat rings, these can be applied directly to the skin. But more commonly the flat side is applied to the skin barrier of the pouching system once sized or shaped to the desired dimensions. It is important that the ring not be overstretched.

To provide skin protection, stretch the ring to the shape of the stoma. This will help provide skin protection. Deeper convexity can be attained by stacking rings or by adding a convex barrier ring to an already convex skin barrier. To achieve flexible convexity, a convex barrier ring can be added to a one-piece flat pouch. This creates a convex shape, but does not add the firmness that an integrated convex pouching system has.

Barrier strips are strips of extended wear barrier material that can be used to help fill in uneven skin surfaces. They can be cut, bent, and stacked together to improve the fit of a skin barrier on a pouching system. Barrier strips are different than paste strips, although they can be used for a similar purpose. Barrier strips have a different reimbursement code, and tend to be more resistant to erosion than paste strips.

Ostomy paste is a common accessory that is used as a “filler” to help prevent leakage under the skin barrier, and to level uneven areas (e.g., creases, scars). Contrary to its name, ostomy paste is a caulk – not glue. It does



Does your **seal** become

**Gooney**  
and **mushy?**



Does the  
edge of your bag

**Lift?**










Does your

**paste**

**Stretch**  
with you?



**Table 1. Peristomal Skin Products**

Accessory	Common Uses	Tips and Techniques*
<p><b>Flat Barrier Rings</b></p> 	<ul style="list-style-type: none"> <li>• Fill in an uneven skin surface</li> <li>• Enhance durability of pouching system</li> <li>• Fill in a gap between the stoma and the skin barrier opening on your pouching system</li> </ul>	<ul style="list-style-type: none"> <li>• Rings may be stretched to fit your stoma size</li> <li>• Apply to clean, dry skin or apply to the adhesive side of the skin barrier on the pouching system</li> <li>• Does not contain alcohol</li> </ul>
<p><b>Convex Barrier Rings</b></p> 	<ul style="list-style-type: none"> <li>• Add depth to a convex product or to add flexible convexity</li> <li>• Create a custom shape to improve the fit of the pouch</li> </ul>	<ul style="list-style-type: none"> <li>• Available in round and oval</li> <li>• Apply to clean, dry skin or to the adhesive side of the skin barrier</li> <li>• May be stretched slightly to fit your stoma - do not overstretch</li> </ul>
<p><b>Barrier Strips</b></p> 	<p>Help fill in a crease to prevent leakage</p>	<ul style="list-style-type: none"> <li>• Strips can be cut to various lengths.</li> </ul>
<p><b>Ostomy Paste (tube or strips)</b></p> 	<p>Seal around the skin barrier opening</p>	<ul style="list-style-type: none"> <li>• Paste is not an adhesive or glue</li> <li>• Too much paste can interfere with a good pouch seal</li> </ul>
<p><b>Stoma Powder</b></p> 	<p>Help dry moist skin<sup>†</sup></p>	<ul style="list-style-type: none"> <li>• Dust on and brush off excess powder</li> <li>• Optional: may be instructed to seal with a skin barrier wipe</li> <li>• Stop using when skin heals</li> </ul>
<p><b>Skin Protective Wipes or Spray</b></p> 	<p>Remove skin barrier or tape more easily from fragile skin</p>	<ul style="list-style-type: none"> <li>• Use on intact skin</li> <li>• Allow to dry completely before applying the pouching system</li> <li>• May decrease wear time if used with extended wear skin barriers</li> <li>• Some contain alcohol</li> </ul>
<p><b>Adhesive Remover Wipes or Spray</b></p> 	<ul style="list-style-type: none"> <li>• Remove adhesive residue</li> <li>• Ease the removal of tape or skin barrier</li> </ul>	<ul style="list-style-type: none"> <li>• Usually not needed with each pouch change</li> <li>• Must be washed off with water after use</li> </ul>
<p><b>Liquid Adhesive</b></p> 	<p>To improve the adhesion of the skin barrier to the skin</p>	<ul style="list-style-type: none"> <li>• Sprayed on or brush applicators</li> <li>• Applied to skin or skin barrier</li> </ul>

\*Refer to specific instructions for use. <sup>†</sup>Consult your healthcare professional for skin and stoma problems. Product photos courtesy of Hollister Incorporated.

not increase adhesion, which is a common misconception. In fact, too much paste can actually decrease wear time of a pouching system.

An alternative to paste are flat barrier rings. The rings are more resistant to stomal discharge and are generally preferred over paste if the output is urine. Clean up is often easier.

If using paste, it is good to be aware that many brands contain alcohol. If you notice a stinging sensation when applying the paste to your skin, examine the peristomal area for irritation and consider using barrier rings instead. The paste is usually applied to the skin barrier before applying to the skin. Allowing the paste to "set up" before applying to the skin allows for some of the alcohol to evaporate. Paste is available in strips and in a tube. The cap on the tube needs to be replaced tightly after use, so the paste does not harden in the tube.

Stoma powder is suggested for times when there is minor peristomal irritation, and the skin is moist or weepy. These powders absorb moisture, which helps the skin barrier to adhere since it is dry instead of wet. It is not a preventative tool as the dry powder can interfere with the skin barrier adhesion.

Whenever your skin is broken or red, it is critical to determine the cause of the irritation. The powder does not resolve that. If skin irritation persists, it is important to seek the advice of a qualified healthcare professional. Repeated leakage and skin irritation is never normal.

To use the powder you should dust it over the moist skin, and let it absorb so that you have a dry surface area. Excess powder should be brushed off so as not to interfere with the adhesion of the pouching system. Some clinicians may

recommend the addition of a prep wipe over the powder to create a crust. When the skin is healed, the use of the powder should be discontinued.

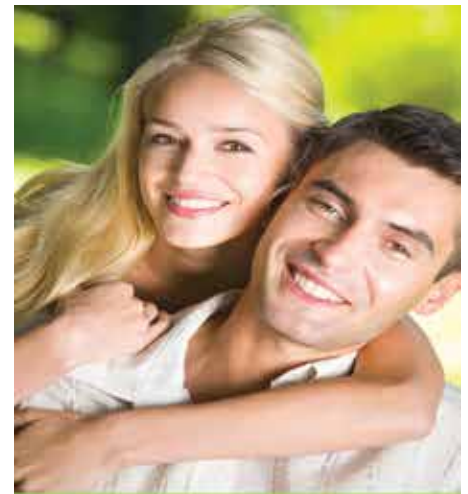
Skin protective wipes or skin preps are generally used before pouch application, and are intended to protect the skin when an adhesive is removed.

They provide a thin film to prevent the stripping off of the top layer of skin (epidermis) during adhesive removal. This accessory is especially helpful for those with fragile skin (e.g., elderly, those on steroids, fair skinned individuals, some diabetics), or if you are removing your pouch frequently (e.g., using a closed pouch). If you have "normal" skin and you change your pouch at regular intervals (e.g., every three to four days) you probably do not need this accessory.

When using these wipes, it is advisable to allow the film to dry completely before applying your pouch. Many people believe that these wipes improve the adhesion of their skin barrier. However, they do not contain any adhesive materials, and it may be harmful to trap those chemicals on the skin. They are best used on intact skin since many do contain alcohol, which can result in a temporary stinging sensation when applied. The use of these skin prepping agents is usually not recommended with extended wear skin barriers, as they may cause a decrease in your wear time.

Adhesive remover wipes are another accessory which can help maintain skin health around your stoma. If there is significant residue from the adhesive (skin barrier or tape) remaining on your skin, it

***"Stoma powder is suggested for times when there is minor peristomal irritation, and the skin is moist or weepy."***



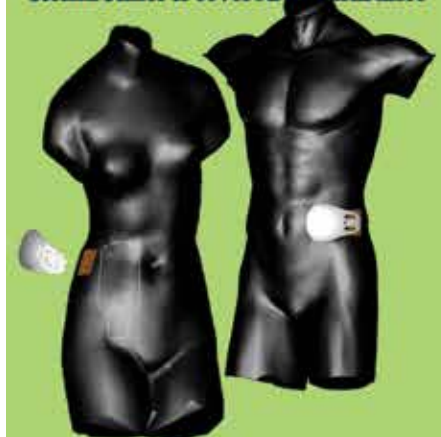
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*continued on page 67*

# Basic Colostomy Care

## Learning the ins and outs of basic stoma care and pouch management

By Leslie Washuta, RN, BSN,  
CWOCN

Learning to care for your new colostomy can seem like a very daunting task – odds are you have no experience in this very personal care. It's definitely uncharted waters. Fear not! With the help of capable ostomy nurses and the support of family, friends, support groups and mentors, as well as your inner strengths, you'll learn the critical skills and will develop the confidence to provide your own ostomy care.



Photo courtesy of Coloplast

discharge from the stoma is stored until you empty or change the pouch. It is usually attached with adhesive to the skin surrounding the stoma (peristomal skin). A non-adhesive system is available, but it is unlikely that you will be introduced to this system initially.

Another major function of an ostomy pouching system is to provide protection for your skin, as the stool that is expelled can cause irritation or soreness if it has constant contact with your skin. Using an appliance that adheres properly generally prevents skin irritation.

### After Colostomy Surgery

There are, of course, many things to learn in a relatively short period of time. Considering that the average hospital stay following surgery is usually five days, you cannot begin to learn it all while in the hospital. If you do, you'll surely qualify for the "new ostomate of the year" award! Realistically speaking, there are just too many topics to cover and you may not be clear mentally for several days following anesthesia.

Ostomy patients are generally released from the hospital once all the tubes are out and a liquid or soft diet is tolerated. For a colostomy, it may be that your ostomy has not actually worked yet! Talk to a discharge planner before leaving and ask to be referred to a home care nursing agency so you can continue the vital ostomy teaching that has been started by the nurses in the hospital.

Let's consider some of the daily aspects of caring for your ostomy. These are critical to developing knowledge and confidence as you recuperate from your surgery and eventually get back into your daily routine.

Because the ostomy will function unpredictably, at least initially, virtually every person with a new ostomy will be taught to wear an "appliance" or pouching system. The pouching system serves as a collection reservoir on the outside of your body where the

### Pouching Systems

You may have fairly regular bowel movements each day depending on your surgery, how much colon was removed, eating habits and your bowel habits before surgery. If your bowels move once or twice a day, you may choose either a closed-end or a drainable pouch. Closed-end pouches are usually discarded when changed after a bowel movement, whereas drainable pouches are almost always emptied, the outlet cleaned and used again for several more days. Both styles are available as a one-piece or two-piece system.

Pouching systems are made of two primary components: a wafer (also called a skin barrier or faceplate) and a pouch. The back of the wafer is covered with adhesive to attach to your skin and has a hole in the center for the stoma to fit through. It is designed to protect your skin from stoma output and is an "anchor" for the pouch. The pouch can be transparent or opaque, drainable or a "closed end" and offered in different sizes and styles.

### One-Piece or Two-Piece

Furthermore, all pouching systems are either one-piece or two-piece systems. With a one-piece system, the skin barrier and pouch are manufactured as one unit. A two-piece system consists of a skin barrier and

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*From left: Sclena one-piece pouches (left has a convex wafer) – note the built-in flushing mechanism; ConvaTec drainable, two-piece pouch. Coloplast one-piece, closed end pouch.*

pouch that are joined together. Usually, a snap-on ring or Tupperware® style seal is used, but a newer style uses an adhesive coupling method. See page 26.

In a two-piece system, the first piece, the wafer, is placed on the skin and can stay there for several days. The pouch can be snapped on and left in place or it can be removed as often as necessary to empty, clean or change it. With a two-piece system, you can switch between a closed-end and drainable pouch without removing the wafer. Probably the biggest disadvantage of a two-piece system is making sure that the wafer and pouch are lined up and properly snapped together. If not done properly, the pouch could unexpectedly come off. Fortunately, this rarely happens.

The one-piece systems tend to be easier to use since there is one less step to the application procedure. It may be a little challenging to “line up” the opening of the skin barrier exactly with the stoma. One trick to properly centering the pouch over the stoma is folding the pouch in half. The bottom half can be aligned with the bottom of the stoma and then unfolded to position over the top half. This may be more difficult if the pouch is opaque. With a one-piece system, you cannot remove the pouch without removing the skin barrier, which is possible with a two-piece system.

## Changing Systems

Your initial choice in an appliance style will be guided by the products available at the hospital where your surgery was performed and by the knowledge of the nurses who are teaching you. As you become more knowledgeable about living with your ostomy, chances are that you may want to change to an appliance that offers different features from your original product. Talk to your ostomy nurse or product manufacturer to determine what’s right for you or reach out to UOAA affiliated support group members for suggestions on what has worked for them.

## Accessories

In addition to the basic pouching system, ostomy

accessories may be a part of the fine-tuning process to enhance wear-time, comfort or stoma management. These accessories include skin prep, stoma paste or strip paste, adhesive rings/sprays and convex rings as well as belts for support and hernia management.

These products are designed to improve skin barrier adherence if you have dimples, folds, a flat stoma or problems with leakage. Stoma powder is also available for use under the wafer for sore skin. See an ostomy nurse if you think you need any of these products.

Other accessories include items such as an ostomy belt, ostomy deodorant drops or spray and oral deodorant tablets. The belt, if needed, attaches to tabs on either side of the pouch, snugly but comfortably encircles the body, and helps lend support to the appliance. The deodorizing products help to cut down on the odor in the pouch or those formed in the gut.

Adjustments in your product choices may be needed based on the characteristics of your stoma and stoma site. One look at any ostomy product catalog will tell you that there is an overwhelming number of ostomy products and accessories to choose from! Making a choice or product change is best done with the advice of a professional, such as your ostomy nurse, who has experience in fine-tuning product selection to meet your specific needs and will be glad to offer you guidance in this area.

## Wear Time

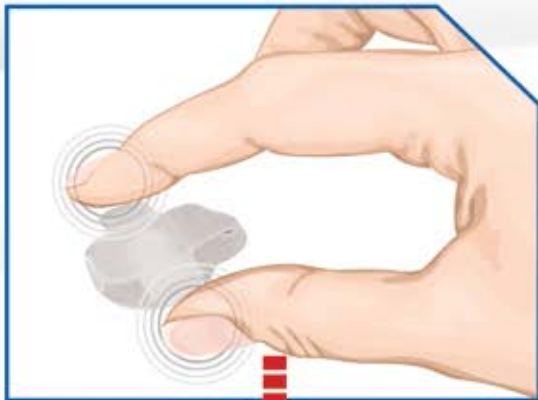
How often you change the appliance will depend on personal preference as well as your stoma characteristics. It’s best to set up a regular schedule. Think in terms of every four or five days and make notes on your calendar that will keep you on schedule. Your wear time may be reduced if the stoma is flat or is located in a recessed or dimpled area or if your stool is watery. Build some flexibility into your schedule and change earlier rather than later if at all in doubt. As you gain more experience, you will develop a routine that suits you best.

## Changing Your Pouch

Your basic products will include a towel and wash-cloth, new pouch and/or skin barrier, scissors (if cutting the wafer opening), any accessories you are using and

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a trash bag. Don't forget your pouch clip if needed. Toilet paper is also handy for wiping around the stoma should any fecal matter be expelled as you work. Gloves are not necessary, just good hand washing before and after are sufficient.

First, prepare your new wafer. Wafers come either pre-cut or "cut-to-fit," which requires a little craftiness with the scissors on your part. Chances are you will be using a cut-to-fit wafer for the first four-to-six weeks after surgery while your stoma is shrinking or if your stoma is oval rather than relatively round. Most pre-cut wafers have round holes, although custom products can be ordered from several manufacturers. If you're cutting your wafer opening, do so ahead of time.

Use the size markings on the wafer backing or trace the proper measuring guide circle or your own pattern onto your wafer, then cut with your scissors. Be sure to use a pattern no more than 1/8" larger than your measured stoma size. Remove the paper backing and then add any stoma paste, adhesive strips or adhesive rings (if applicable) to the back of the skin barrier. Then set that wafer aside with the sticky side facing up.

If using a drainable product, attach the tail clip or close the end and insert deodorant drops into the opening of the pouch if you use them. As you remove your old wafer or skin barrier, you may find that using an adhesive remover wipe will help break the adhesive seal and is a little gentler and kinder to your skin. Those fine hairs under your wafer may also thank you for it! This product also helps to remove any wafer or paste residue left behind on the skin. Be certain to wash all the remover solution off before proceeding with adhering your new wafer or appliance.

## Skin Care

The next and very important step is proper skin cleansing of the ostomy site. You can do this either sitting or standing near the sink or in the shower with your appliance off, using a soft wash cloth or paper towels. Soap and water are often recommended for routine care of the skin surrounding the stoma; however, some people use plain water for their skin care routine. Ostomy safe wipes are also available.

Exercise caution if opting to use disposable, pre-moistened wipes for your skin cleansing as many of



*From top: Coloplast Brava® strip paste; Nu-Hope support belt; ConvaTec Eakin Seal; Hollister pouch lubricating deodorant; Nu-hope adhesive.*

these products contain lanolin that can interfere with the adherence of your new appliance – check the label. Please note that the stoma itself does not require cleaning; just wipe off any stool with toilet tissue.

Inspect your skin around the stoma, noting any redness or sore areas that will require extra attention or treatment. A hand mirror will help you look along the lower border of the stoma if unable to visualize it otherwise. The skin under your wafer/skin barrier should look like the skin elsewhere on your abdomen. If you notice increased redness or sore skin, examine the back of the appliance or wafer you just removed to look for signs of leakage such as uneven wear.

Peristomal skin will most likely stay "healthy" if your appliance is sticking well and you change it on a routine schedule before the adhesive gives way. Please don't wait until it leaks to decide it's time to change it – chances are you'll have reddened or even sore skin if you procrastinate! Not fun!

## Solving Skin Irritation

If skin irritation does occur, try to figure out why. Your stoma site may have irregularities as mentioned above and the stool undermines the adhesive seal. You may need to add accessories such as paste, barrier rings or strip paste or a convex wafer with a belt to compensate. It would be best to discuss this with your ostomy nurse or call the product hotline of the supplies you are using for advice if facing such a problem. Ignoring it won't make it go away! Remember, an ounce of prevention...

Treat a skin irritation by dusting the irritated skin, once washed and dried, with a powder designed specifically for use around the stoma. Once you have created a dry surface with the powder, seal it to the skin by patting with a "no-sting" skin prep and allow to dry. Then proceed with your ostomy appliance products as usual. Plan to change the appliance a little sooner than usual to check the status of your skin.

In some cases, if a rash occurs around the stoma that is red, raised, and itchy, it may be a yeast infection that will require a special anti-fungal powder application, sealed by skin prep. Actual allergic reactions to ostomy



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products are rare, but should be suspected if other causes are not found. Seek advice from your ostomy nurse or your doctor regarding any ongoing skin redness, rash or irritation, particularly if it has not resolved after one or two appliance changes.

### Pouching Tips

Another option is using a filter. Many, though not all, pouches are designed with a small filter placed near the top. The filter will allow expelled gas to escape from the pouch through a small, pin-sized opening that is backed by an odor-absorbent product, such as charcoal. If your pouch does not have a filter, you can let gas out by opening the tail (if a one-piece) or by “burping” your wafer and pouch where the two-pieces snap together. A venting device may also be applied to the pouch. Do this in the bathroom where fecal odors are expected.

### Controlling Odor

Nearly all new ostomy pouches will not allow odor to escape when properly closed and adhered to your body. Of course, once you open the pouch, any odor present will escape. Fecal odor when you don’t expect it can be the first clue that a leak is imminent. Adding

a pouch deodorant is considered optional, but practiced by many people with a colostomy. Special liquids, droplets or sprays will help cut down or eliminate odor.

This makes it a little nicer for you, too, if you are queasy about certain smells. One side benefit of deodorant drops or sprays is that they often “lubricate” the inside of the pouch, making for easier cleaning if you opt to re-use your pouches. Orally-ingested products are also available to help deodorize the stool internally before it gets to the pouch. Your ostomy nurse can advise you further about using these products.

### Resources

*United Ostomy Associations of America (UOAA) is a great resource with an online discussion board, local support group information, educational material, webinars and ostomy videos. Visit their website at [www.ostomy.org](http://www.ostomy.org) and if questions contact them at [info@ostomy.org](mailto:info@ostomy.org) or 800-826-0826. For additional information contact your ostomy nurse, local support group leader, or follow UOAA on social media. The Phoenix magazine, the official publication of UOAA, is also a great resource: [www.phoenixuoaa.org](http://www.phoenixuoaa.org) or call 800-750-9311 for more information.* ☂



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# Colostomy Irrigation

## A tried and true method of controlling colostomy output

By Ian Settlemyre, *The Phoenix Magazine Editor*

Persons living with a colostomy who practice irrigation experience several quality-of-life benefits. The main one is being able to control the evacuation of stool. It's common to go 24–48 hours without any stomal output and to see a reduction in gas formation. Despite such a dramatic benefit, a recent survey of ostomy nurses found that over half do not teach irrigation to their patients.

Irrigation is the instillation of lukewarm tap water through the stoma, which stimulates peristalsis and contractions of the colon leading to the evacuation of stool. It is similar to an enema and a well-established, optional procedure used by those with descending or sigmoid colostomies to regulate and manage bowel elimination. It is considered a safe and effective method for bowel control that may result in fecal continence and reduced pouch usage.

### History

In a 1985 survey of colostomates at the Mayo Clinic, all had been taught irrigation prior to discharge. Sixty percent were continent with irrigation, 22% were incontinent with irrigation and 18% had discontinued irrigation for various reasons. A 2014 survey of ostomy nurses found that the education of ostomates has drastically changed. Of the 981 respondents, only 18.4% routinely teach irrigation; 19.6% do so only if the patient requests instruction; 9.4% do so only if a physician orders it; and 47.4% do not routinely teach irrigation. More than half (59%) believe irrigation has tangible benefits for patients.

Not all ostomy nurse teaching programs provide hands-on training or even mention irrigation in their curriculum. Additional factors may include the improved adherence and odor-proof qualities of current systems, misguided fear of perforation, frequent cramping and dependence on irrigation.

### Candidates

Appropriate ostomates for irrigation are those who have a left-sided descending or sigmoid colostomy who had regular bowel habits before having an ostomy. Contra-indications are individuals with stomal prolapse, stomal stenosis and peristomal hernia. Individuals undergoing chemotherapy and/or radiation treatments to the abdominal/pelvic area or those with Crohns' disease should not irrigate. Individuals taking diarrhea-causing medications should not irrigate either.<sup>5</sup> Children are not appropriate for this procedure except for prescribed diagnostic procedures.

The ability to perform irrigation requires good manual dexterity and ability to maneuver around your bathroom safely and with ease. Time spent irrigating, often considered a disadvantage, requires about one hour to perform at the same time of day every one to two days. Individuals who work varying schedules might not have the time to dedicate to this practice.

The willingness to perform the hour-long ritual every day at the same time of day is important to training your

bowels. The individual must also be very comfortable with their stoma, able to touch it along with the dexterity to insert the irrigation cone and then instill the water. Some people are quite squeamish about this procedure and can't stomach it. Colostomy irrigation is a personal choice that only you can make.

Irrigation is particularly good for spinal cord injured individuals or any person with disabilities that has limited ability to empty or change their ostomy pouching system. It's easy for caretakers to do and can improve their quality of life, too! If the individual is bedbound, position the head of the bed to at least 45 degrees and follow the steps below emptying the contents into a basin. If wheelchair-bound, pull up next to a

### Advantages

- Not wearing/emptying a pouch
- Control of stoma output
- Self-Confidence
- Cleanliness
- Reduced odor

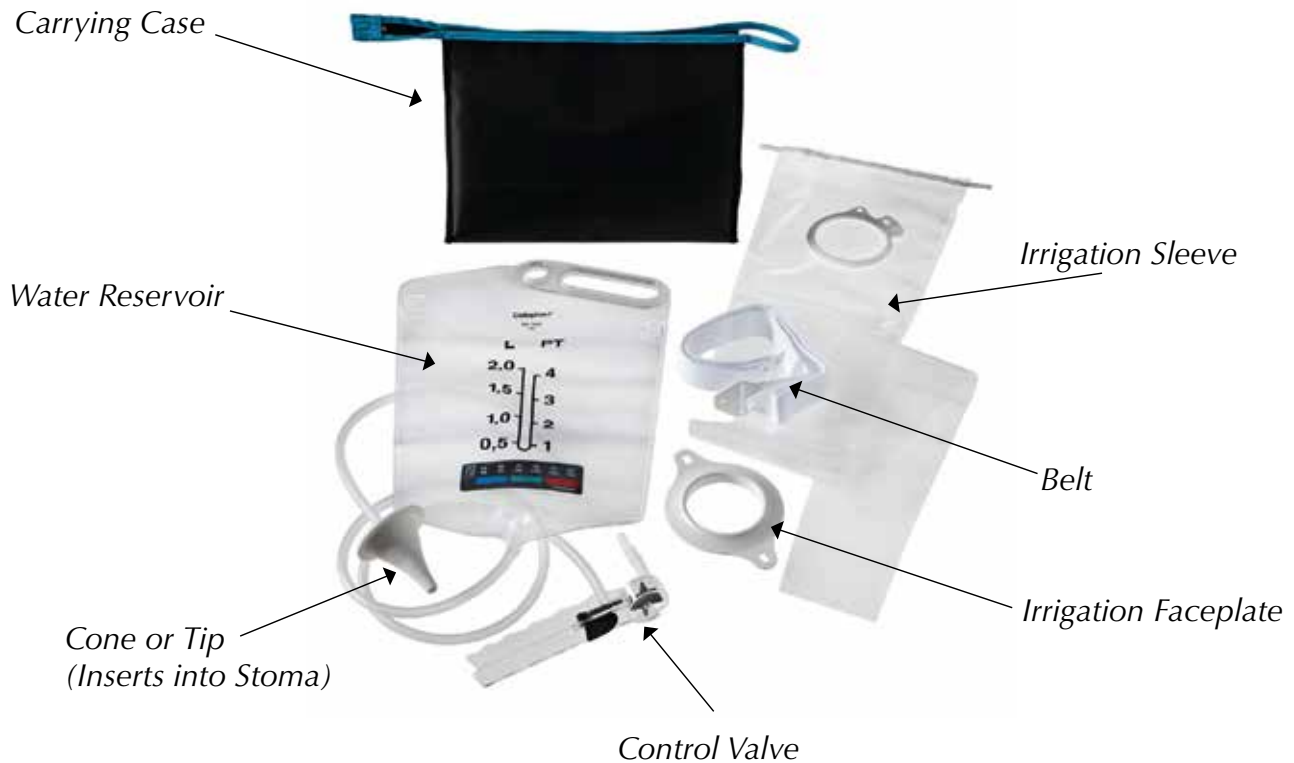
### Disadvantages

- Time commitment
- Scheduling commitment
- Manual dexterity required
- Cramping

### Contraindications

- Poor vision
- Poor manual dexterity
- Lack of motivation
- Irritable bowel syndrome
- Peristomal hernia
- Radiation damage to the bowel
- Diverticulitis
- Crohn's disease
- Serious heart or kidney disease

## Coloplast Irrigation Kit



toilet or other receptacle to empty contents. This is an excellent method of managing bowel continence in paraplegics and quadriplegics.

### The Equipment

1. A two-liter irrigation bag with measurements. Some have a color-coded thermometer.
2. Tubing with flow regulator
3. One malleable, soft cone
4. Water-soluble lubricant
5. An irrigation drain sleeve
6. Ostomy bag clamp or clips
7. Ostomy belt
8. Clean, warm tap water and working plumbing
9. A clothes' hanger or wall hook for the irrigation bag

Other amenities that may make you more comfortable during the procedure are a padded toilet seat, a washcloth or towel, a small table or chair, air freshener and a radio.

### Preparation

First, you must have permission from your physician before attempting this procedure and to obtain the supplies. Secondly, it is highly recommended

to have an ostomy nurse teach you how to perform irrigation. Individuals can learn to successfully irrigate anytime they are willing and have their doctor's blessing.

Occasionally, with the initial irrigation, some ostomates will experience a feeling of lightheadedness, sweating and even fainting – a vasovagal response. The sight of the irrigation cone being inserted into the stoma or simple nervousness can cause this, just like seeing blood or being squeamish. This reaction is usually harmless and does not require any treatment other than lying down and letting the blood flow back to your brain.

The volume of solution used to irrigate the colostomy has not been standardized. Volumes varying from 250 ml to 1500 ml have been recommended, but studies have not been conducted to determine the optimal volume of fluid required. Nevertheless, several studies reported frequent passage of stool between irrigations when 250 ml was used to irrigate a colostomy, and two authors recommended 750 ml as the optimal volume needed to achieve complete bowel evacuation and absence of stool passage from the colostomy for a period of one to two days.

## Procedure

1. Prepare your equipment.
2. Attach the irrigation cone to the irrigation tubing.
3. Fill the irrigation bag with 1000 ml of warm water.
4. Place the irrigation bag at shoulder height when seated.
5. Open the regulator clamp on the tubing to remove the air. Reclamp the tube.
6. Remove your colostomy pouch. If it's a two-piece, leave the barrier in place.
7. Place the irrigation sleeve over your stoma or attach it to the barrier. Ostomy belt optional.
8. Sit on the toilet or on a chair next to the toilet, and let the narrow end of the sleeve hang into the toilet.
9. Use water-soluble lubricant on the stoma cone and gently insert it into the stoma lumen until it fits snugly (from the top of the sleeve).
10. While holding the cone in place with one hand, open the clamp on the tubing to let 500–1,000ml of water flow slowly into your colon over 5-10 minutes. The key is to use enough fluid to cause a return; most people start with 500 ml.<sup>9</sup> Regulate the flow of water using the clamp.
11. Once the amount of water is instilled and you feel your colon distending, clamp the tube and hold the cone in place for about a minute, then remove the cone from your stoma.
12. Close the top of the irrigation sleeve and wait for the return to flow into the toilet. Most is expelled in the first 10-15 minutes, the rest can take another 15-30 minutes. During this time, you can fold up the irrigation sleeve and walk around and do other things.
13. Once the returns are completed, remove the irrigation sleeve, clean your skin or shower, and apply a stoma cap or a mini pouch if using a two-piece pouching system.
14. Wash equipment with mild dish soap or vinegar and warm water, hang to dry and store in a clean container between uses. It is not necessary to sterilize the equipment.
15. Repeat daily at the same time and your bowels should start to become regulated and you feel confident that there will be no activity between irrigations.
16. When you are confident in a 24-hour interval, you may want to try to increase the time between irrigations to 48 hours.

## Patient Experience

The authors of a recent study in Sweden interviewed 39 patients (18 men and 21 women) who were managing their colostomies by using irrigation. Positive aspects described by these patients included feeling secure in social settings, having an empty pouch, having less

### Irrigation Tips and Tricks

- The irrigation performance you experience is dependent on your diet, how much colon you still have, your fitness and the amount of exercise you take. No-one can predict accurately what is possible for you, and you will have to experiment for yourself.
- If you are seeking to increase the time between irrigations, increase the quantity of water by 100ml at a time, but use the same quantity at least three times before changing again.
- Make sure that the water you are using is actually entering the stoma and not leaking away.
- If you need to be out promptly every morning, consider irrigating in the evening, but preferably do not keep changing between morning and evening irrigations.

frequent pouch changes, a general sense of enhanced freedom, enhanced bowel control, feeling more clean, improved self-esteem, feeling confident in intimate situations, diminished anxiety, and reduced odor. Negative aspects reported by 56% of the patients included the time required for irrigation, a loss of flexibility due to time needed to plan for irrigation, prolonged occupation of the toilet, more flatulence, and the technical demands of the procedure.

Adrian March, consultant to the UK Colostomy Association and webmaster for [www.stomadata.com](http://www.stomadata.com), has been irrigating for well over ten years. "I am able to achieve three days with no stoma output at all; however, this is fairly uncommon. Most people irrigate daily or every other day. I find that irrigation is so effective that no feces is emitted from my stoma and the stoma cap or pouch only shows a slight trace of mucus. Occasionally, the effect of irrigation does not last for the full time. This can be due to a change of diet or some disturbance of the bacteria in the gut when taking antibiotics or from food intolerances."

## Conclusion

Bowel continence is so important to our self-esteem and social life. Those who do not have a colostomy, or before you were an ostomate you probably took pooping for granted. If an ostomate can regain control over his bowels it can have a major impact on his quality of life. "Colostomy irrigation may not be easy at first," says ostomate Brian McKeown of New Zealand, "but you get so much freedom in your life when you do, no more leaky bags or accidents when out in society, and far less passing wind." Much of the success will depend upon your dedication to learn and practice this ritual.

This article is not intended to provide medical guidance or replace the education of your ostomy nurse. 🍴

# Beautiful Butte

## A performer shines brighter and better than ever

By B Redner

Softly, but firmly, the gastroenterologist spoke, “Your hips will have to wait.” The patient, a singer, songwriter and dancer, pleaded, “But my hips can’t wait! The orthopedic surgeon said I have bone-on-bone. My act has been favorably compared with Charo’s. I need to dance.” Pulling her seat up close to Melissa Marshall, nearly touching nose to nose, the physician gravely stated, “You have to put off hip surgery. This is a case of life and death. You have a very large mass low down sitting on your sphincter muscles.”

### Master Music Classes

Picture a young girl who dreamed of a life of music and performing. Now envision that girl backstage at the fabulous Diplomat Hotel in Miami Beach, where the most famous singing idols of the 1970s performed nightly. Teenage Melissa Marshall stood a mere 20 feet from Frank Sinatra belting out “New York, New York,” followed a week later by Sammy Davis, Jr. blasting his version of “Birth of the Blues.” Subsequent weeks brought Aretha Franklin, Diana Ross, Burt Bacharach, and an unending schedule of superstars to grace that same stage to sing their classic hits.

Melissa not only enjoyed their music, but surreptitiously attended a private master class just by listening and watching how each star practiced their craft and “worked” the audience. She learned how to breathe properly, how to phrase lyrics, when and how to share the stage with an orchestra. She observed what worked and what didn’t. She learned what to say when a song tanked and what to do when one blew the roof off. By the time she started at the University of Miami where she majored in jazz-vocal music, she found herself already well prepared for a singing career.

Sure enough, shortly after finishing school, Melissa



formed her own band, aptly named, The Marshall Arts Band and launched her career. The seven-piece band played the Sheraton and Marriott circuit between Texas and Illinois. In 1986, a big break catapulted Melissa and the band, by invitation only, to Atlantic City casinos where she would perform at two or three casinos every day during the city’s boom years.

### First Signs and Symptoms

In 2012 Melissa experienced rectal bleeding, but passed it off as an aging issue. She cut back on her hectic performance schedule. She told no one about the bleeding. A year later, during an examination prior to hip surgery, she learned the hard fact that she had a tumor.

"I was shocked," recalls Marshall. Mixed emotions tumbled all together. "I didn't know my capacity to be so strong. I'm not gonna lie, I had my very down moments."

However, she says, "My girlfriends were so very stout. At the beginning we went out for a girl's night. We laughed and cried in the hotel room. It was an unbelievable bonding experience."

Melissa immediately scheduled an appointment with a gastroenterologist who performed a nearly three-hour colonoscopy which is normally a 30-minute procedure. "The doctor cut away a large portion of the tumor because if she hadn't, within a short time, it would have occluded my colon and possibly gone septic. I could have died," Marshall said. A few days later she learned the tumor was malignant. Melissa's world froze in place. She had to wait six agonizing weeks to allow her body to heal from the first surgical procedure before undergoing the next operation.

This news challenged life as she knew it. A somber time followed when she evaluated what was important and what wasn't. She had to endure the trauma of surviving a life-threatening cancer rather than worry about the next singing gig. The colorectal surgeon held out hope that Melissa could have her intestines reconnected after ostomy surgery, but such wouldn't be the case. Her ostomy would be permanent. It was a life-altering crossroad. "I didn't know if I'd ever sing again," Marshall admits.

Three days after ostomy surgery, Melissa's bad-news blitz continued – her cancer had spread. It would require chemotherapy and radiation. She quickly arrived at her physical and emotional cellar. How would she respond? Thirteen days later she received a partial answer while being driven home from the hospital. Melissa experienced a vision.

## Vision of Transformation

Dancing before her eyes, nearly within reach, was the common symbol of transformation, a butterfly. Its body was a loop of ribbon, the international symbol for cancer awareness. The wings were glittering jewelry.

"As soon as I arrived home, I rushed to my table and drew the image. I called a jeweler to craft my design," Marshall recounts. A few days later lyrics to a new song floated into her consciousness: "No You Cant'cer." She contacted her keyboard player and set her words to

original music. Delighted with the effort, she wondered if she'd ever be able to perform it. A few months later, she wore the first butterfly necklace.

## A Foundation Is Born

She received so many compliments and requests for the necklace, she initiated a project to find a means to affordably mass produce it. After eighteen months, she finally felt strong enough to go into the studio and record the song. With so many requests for the CD and necklace, Melissa incorporated a new charity, the No You Cant'cer Foundation.

Without much thought or planning, Melissa established the foundation and generated revenues from the sale of necklaces and CDs. She also discovered she had a massive platform to

advance the cause of ostomy and cancer awareness. She wrote, designed, and printed an information trifold, "It's in the Bag," which is distributed free to medical facilities. So many positive activities left little room in her life for negativity.

Melissa muses, "Is it possible to say that cancer and the required surgery became the best thing to have happened to me?" A question that needs no definitive answer. A new world of possibilities had opened for her, a world where ego gratification and monetary gains lost importance.

## Now Serving Others

Now cancer free, Melissa subscribes to the philosophy that we are placed on this earth to serve others. Melissa sought out a United Ostomy Associations of America support group. There, she learned that educational needs are many and is attempting to fill them. As an advocate, she passed UOAA's Visitor Training course. She has gone even further by attending and graduating "Wild on Wounds," a hospital-sponsored course that enables her to counsel and advise ostomates.

She accepted the post of social host for UOAA's 2019 National Conference where, in addition to planning many events, she performed both of her original songs, "No You Cant'cer" and "UOAA Freedom."

Melissa wants to diminish the stigma attached to ostomy surgery. She would like emergency ostomy provisions available at stadium aid stations and in emergency vehicles. She wants to alleviate or at least diminish fear for those about to become ostomates. In view of her accomplishments to date, perhaps it wouldn't be wise to bet against her achieving these lofty goals.

For more information about Melissa and her foundation, visit <https://noyoucantcerfoundation.org>. 🦋

# Basic Ileostomy Care

## Learning the ins and outs of basic stoma care and pouch management

By Leslie Washuta,  
Certified Ostomy Nurse

Learning to care for your ileostomy can seem like a very daunting task. It's definitely uncharted waters. Fear not! With the help of capable ostomy nurses and the support of family, friends, support groups and mentors, as well as your inner strengths, you'll learn the critical skills and will develop the confidence to provide your own care.

### After Surgery

Considering that the average hospital stay is five days, you cannot begin to learn it all while in the hospital. If you do, you'll surely qualify for the "new ostomate of the year" award! Realistically speaking, there are just too many topics to cover and you may not be clear mentally for several days following anesthesia.

Ostomy patients are generally released from the hospital once all the tubes are out and a liquid or soft diet is tolerated. An ileostomy can be expected to start "functioning" within the first few days and you will have at least passed that hurdle before going home. Be sure to talk to a discharge planner before you leave the hospital and ask to be referred to a home care nursing agency so you can continue the vital ostomy teaching that has been started by the nurses in the hospital.

With an ileostomy, output may be up to 1200 ml (40 ounces) per day, making pouch disposal every time the pouch fills unrealistic. Ileostomy pouches should be emptied when they are 1/3 to 1/2 full. Generally, this is six to eight times per day. Emptying the pouch can be done while it's on your body or, if using a two-piece system, you may opt to remove it or replace it with another pouch. The particulars of how you clean your pouch will become a matter of personal preference; some ostomates will empty the pouch contents while still wearing the pouch and then wipe down only the



Photo courtesy of Coloplast

last two-to-three inches (known as "the tail") on a drainable pouch, before reattaching the clip or closing the end with the velcro-type built-in closure system.

Others will drain out any fecal matter, then add water to the pouch through the open tail to wash down any fecal residue stuck to the inside, then empty and then clean and close the tail. An innovative pouch has a built-in cleaning system that connects to a water line and "flushes" contents out. There is no one "right way." It's a matter of personal prefer-

ence, convenience and circumstance.

### Pouching Systems

Pouching systems are made of two primary components: a wafer (also called a skin barrier or faceplate) and a pouch. The back of the wafer is covered with adhesive to attach to your skin and has a hole in the center for the stoma to fit through. It is designed to protect your skin from stoma output and is an "anchor" for the pouch. The pouch can be transparent or opaque, drainable or a "closed end" and offered in different sizes and styles.

### One-Piece or Two-Piece

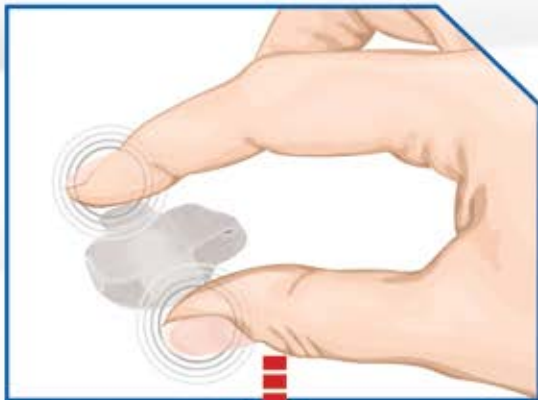
Furthermore, all pouching systems are either one-piece or two-piece systems. With a one-piece system, the skin barrier and pouch are manufactured as one unit. A two-piece system consists of a skin barrier and pouch that are joined together. Usually, a snap-on ring or Tupperware® style seal is used, but a newer style uses an adhesive coupling method. See page 26.

A two-piece system offers a few more variables when being applied and also during the course of wear-time. The first piece, the wafer, is placed on the skin and can stay there for three to five days. The pouch can be snapped on and left in place or it can be removed as



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*Left: a two-piece drainable pouch from Coloplast that uses adhesive coupling. Right: a one-piece drainable pouch with convexity from Marlen Manufacturing.*

often as necessary to empty, clean or change it. With a two-piece system, you can switch between a closed-end and drainable pouch without removing the wafer.

Probably the biggest disadvantage of a two-piece system is making sure that the wafer and pouch are lined up and properly snapped together. If not done properly, the pouch could unexpectedly come off. Fortunately, this rarely happens.

The one-piece appliances tend to be simpler to use since there is one less step to the application procedure. A disadvantage is it may be a little challenging to “line up” the opening of the skin barrier with the stoma. One trick is folding the pouch in half. The bottom half can be aligned with the bottom of the stoma and then unfolded to position over the top half. The flexibility of a one-piece makes this an easy fix. This may be more difficult if your appliance is opaque and prevents you from seeing through the front of the pouch. With a one-piece system, you cannot remove the pouch without removing the skin barrier, which is possible with a two-piece appliance.

## Changing Systems

Your initial choice in an appliance style will be guided by the products available at the hospital where your surgery was performed and by the knowledge of the nurses who taught you. As you become more knowledgeable about living with your ostomy, chances are that you may want to change to an appliance that offers different features from your original product. Look to your ostomy nurse, product manufacturer or a UOAA Affiliated Support Group for help in fine-tuning your selections in order to determine what’s just right for you.

## Accessories

In addition to the basic pouching system, ostomy accessories may be a part of the fine-tuning process to enhance wear-time, comfort or stoma management. These accessories include skin prep, stoma paste or strip paste, adhesive rings/sprays and convex rings.

These products are designed to improve skin barrier adherence if you have dimples, folds, a flat stoma or problems with leakage. Stoma powder is also available for use under the wafer for sore skin; see an ostomy nurse if you think you need any of these products.

Other accessories include items such as an ostomy belt, ostomy deodorant drops or spray and oral deodorant tablets. The belt, if needed, attaches to tabs on either side of the pouch, snugly but comfortably encircles the body, and helps lend support to the appliance. The deodorizing products help to cut down on the odor in the pouch or those formed in the gut.

Adjustments in your product choices may be needed based on the characteristics of your stoma and stoma site. One look at any ostomy product catalog will tell you that there is an overwhelming number of ostomy products and accessories to choose from! Making a choice or product change is best done with the advice of a professional, such as your ostomy nurse, who has experience in fine-tuning product selection to meet your specific needs and will be glad to offer you guidance in this area.

## Wear Time

How often you change the appliance will depend on personal preference as well as your stoma characteristics. It’s best to set up a regular schedule. Think in terms of every three or five days and make notes on your calendar that will keep you on schedule. Your wear time may be reduced if the stoma is flat or is located in a recessed or dimpled area or if your stool is watery. Build some flexibility into your schedule and change earlier rather than later if at all in doubt. As you gain more experience, you will develop a routine that suits you best.

## Changing Your Pouch

Your basic products will include a towel and wash-cloth, soap (optional), new pouching and/or skin barrier, scissors (if cutting the wafer opening), any accessories you are using and a trash bag. Don’t forget your pouch clip if needed. Toilet paper is also handy for wiping

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around the stoma should any fecal matter be expelled as you work. Gloves are not necessary, just good handwashing before and after are sufficient.

First, prepare your new wafer. Wafers come either pre-cut or “cut-to-fit,” which requires a little craftiness with the scissors on your part. Chances are you will be using a cut-to-fit wafer for the first four-to-six weeks after surgery while your stoma is shrinking or if your stoma is oval rather than relatively round. Most pre-cut wafers have round holes, although custom cut products can be ordered from several manufacturers. If you’re cutting your wafer opening, do so ahead of time.

Use the size markings on the wafer backing or trace the proper measuring guide circle or your own pattern onto your wafer, then cut with your scissors. Be sure to use a pattern no more than 1/8” larger than your measured stoma size. Remove the paper backing and then add any stoma paste, adhesive strips or adhesive rings (if applicable) to the back of the skin barrier. Then set that wafer aside with the sticky side facing up.

If using a drainable product, attach the tail clip or close the end and insert deodorant drops into the

***“Exercise caution if using disposable, pre-moistened wipes for your skin cleansing as many contain lanolin that can interfere with the adherence of your system.”***

opening of the pouch if you use them. As you remove your old wafer or skin barrier, you may find that using an adhesive remover wipe will help break the adhesive seal and is a little gentler and kinder to your skin. Those fine hairs

under your wafer may also thank you for it! This product also helps to remove any wafer or paste residue left behind on the skin. Be certain to wash all the remover solution off before proceeding with adhering your new wafer or appliance.

### **Skin Care**

The next and very important step is proper skin cleansing of the ostomy site. You can do this either sitting or standing near the sink or in the shower with your appliance off, using a soft wash cloth or paper towels. Soap and water are not recommended for routine care of the skin surrounding the stoma; the oils and additives can interfere with pouch adhesion. Ostomy safe wipes are also available.

Exercise caution if using disposable, pre-moistened wipes for your skin cleansing as many contain lanolin that can interfere with the adherence of your pouching system. Please note that the stoma itself does not require cleaning; just wipe off any stool with toilet tissue and you’re all set.

Inspect your skin around the stoma, noting any redness or sore areas that will require extra attention or treatment. A hand mirror will help you look along the lower border of the stoma if unable to visualize it otherwise. The skin under your wafer/skin barrier should look like the skin elsewhere on your abdomen. If you notice increased redness or sore skin, examine the back of the appliance or wafer you just removed to look for signs of leakage.

Peristomal skin will most likely stay “healthy” if your appliance is sticking well and you change it on a routine schedule before the adhesive gives way. Please don’t wait until it leaks to decide it’s time to change it – chances are you’ll have reddened or even sore skin if you procrastinate! Not fun!

### **Solving Skin Irritation**

If skin irritation does occur, try to figure out why. Your stoma site may have irregularities as mentioned above and the stool undermines the adhesive seal. You may need to add accessories such as paste, barrier rings or strip paste or a convex wafer with a belt to compensate. It would be best to discuss this with your ostomy nurse or call the product hotline of the supplies you are

## **Vitamin B12 Deficiency**

This water-soluble vitamin has several important functions in the body. It is needed for DNA synthesis, cell production and development of red blood cells. Without it, anemia can result. A deficiency may present as memory loss, confusion or dementia.

B12 is normally absorbed in the last section of the small intestine known as the ileum. Those who have undergone ileostomy surgery or any other surgery where terminal ileum has been removed are at an increased risk for vitamin B12 deficiency. Active disease in the terminal portion of the small intestine, the ileum, also poses an increased risk. It is estimated that up to 25% of ileostomates have vitamin B12 deficiency. The body can store a three-to-five year supply of the nutrient.

Starting two years after a surgery where the terminal ileum was involved, it is recommended to have B12 levels checked and then checked annually after that. If a deficiency is found, patients may be given injections on a monthly basis.



using for advice if facing such a problem. Ignoring it won't make it go away! Remember, an ounce of prevention...

Treat a skin irritation by dusting the irritated skin, once washed and dried, with a powder designed specifically for use around the stoma. Once you have created a dry surface with the powder, seal it to the skin by patting with a "no-sting" skin prep and allow to dry. Then proceed with your ostomy appliance products as usual. Plan to change the appliance a little sooner than usual to check the status of your skin.

In some cases, if a rash occurs around the stoma that is red, raised, and itchy, it may be a yeast infection that will require a special anti-fungal powder application, sealed by skin prep. Actual allergic reactions to ostomy

***“Seek advice regarding any ongoing skin redness, rash or irritation, particularly if it has not resolved after one or two appliance changes.”***

products are rare, but should be suspected if other causes are not found. Seek advice from your ostomy nurse or your doctor regarding any ongoing skin redness, rash or irritation, particularly if it has not resolved after one or two appliance changes.

Another option is using a filter. Many, though not all, pouches are designed with a small filter placed near the top. The filter will allow expelled gas to escape from the pouch through a small, pin-sized opening that is backed by an odor-absorbent product, such as charcoal. If your pouch does not have a filter, you will need to let gas out either by opening the tail (if a one-piece) or by "burping" your wafer and pouch where the two-pieces snap together. Be sure to do this in the bathroom where fecal odors are expected; use an air freshener out of consideration for others.

Many with an ileostomy will experience output that has the consistency of water or very "liquid" in nature. This can make managing the pouch and keeping the peristomal skin healthy a challenge. There are products that can turn the stomal output to a gel consistency.

### **Controlling Odor**

Nearly all new ostomy pouches will not allow odor to escape when properly closed and adhered to your body. Of course, once you open the pouch, any odor present will escape. Fecal odor when you don't expect it can be the first clue that a leak is imminent. Adding a pouch deodorant is considered optional, but practiced by many people with an ileostomy. Special liquid, droplet or spray products will help cut down or eliminate odor.

This makes it a little nicer for you, too, if you are queasy about certain smells. Orally-ingested products are also available to help deodorize the stool internally before it gets to the pouch. Your ostomy nurse can advise you further about using these products.

### **Resources**

United Ostomy Associations of America (UOAA) is a great resource with an online discussion board, local support group information, educational material, webinars and ostomy videos. Visit their website at [www.ostomy.org](http://www.ostomy.org) or call their information line at 800-826-0826. With over 315 local support groups, they can also connect you with a fellow ostomate for first-hand knowledge and advice. For additional information, contact your ostomy nurse or local support group members, as well as the many ostomy-related social network sites. ☂

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# The Pilates Pro

## Returning to a strong body, peace of mind and positive attitude

By Ryan Hodgkinson

I was a happy, active child with few relatively minor health issues up until the age of eleven. That is when I began experiencing intense stomach cramping, frequent, urgent trips to the bathroom and painful bowel movements. I began to lose weight, became less active and more withdrawn from those around me.

I was taken to a pediatric gastroenterologist who diagnosed me with Crohn's disease. I was immediately put on a daily regimen of metronidazole and prednisone. The medications helped, but I still lived in a constant cycle of partial remission interrupted by sudden, intense flare-ups.

Long-term use of prednisone has a number of serious side effects including loss of bone density and sudden, dramatic mood swings. My mother wanted me to get involved in some sort of physical activity to keep my bones healthy and help me emotionally. I had always wanted to try martial arts and enrolled in a karate class. I immediately took to karate and soon I began to regain strength and better control over my temper. I also began lifting weights and found it to be an enjoyable activity.

As my confidence improved, I began trying out other sports including wrestling. I earned my varsity letter my freshman year while dealing with the ups and downs of Crohn's disease. That all changed when I was seventeen and developed an excruciatingly painful abscess. I had the abscess surgically drained. However, it came back and my surgeon suggested a temporary loop ileostomy. This was my first experience with an ostomy. I was very hesitant to undergo the procedure, but I was reassured that it would only be for a month so the abscess could finally heal. Things didn't go as planned. What was supposed to be a month, stretched out to over a year.

High school with an ileostomy was challenging. I was very embarrassed of my ostomy and lived in constant fear of people finding out about it. When I eventually had my take-down surgery, I was ecstatic. I eagerly returned to karate training and traveled to Japan to compete.

My Crohn's was still very active and the abscess continued to return and need to be drained. During my senior year, I was advised that I should again divert my colon. This time with a temporary colostomy which I had for about six months. I was less secretive about my ostomy this time around, but still didn't talk about it openly and eagerly counted the days until my take-down surgery.

I attended Gonzaga University and once again returned to living with semi-remission and sudden, intense flares. Even so, I continued to train in karate and lift weights and even managed to spend a year living abroad in Italy. After

graduation, I was accepted in to UCLA's Ancient History PhD program.

The abscess returned and my GI argued that my large intestine was too damaged to save and that I needed to undergo a total colectomy. I dreaded the idea of going back to having an ostomy and sought out numerous second opinions. They all came back with the same conclusion: my colon had to go. Graduate school is incredibly stressful without health issues, but now I had to cope with the idea that this ostomy wasn't temporary. There was no going back. I also began to experience pain in my pelvis from scar tissue impacting my peroneal nerve.

I was eventually given the go ahead to begin exercising but wasn't given any direction or advice. I resumed lifting weights and thought I was being smart about it; I started with light weights and always practiced proper form. What I didn't understand was that my core muscles, the postural muscles that help keep the body balanced and are essential to providing good support to the spine had completely atrophied. I essentially had no support for my low back as I lifted weights and soon began experiencing a new pain that radiated down my leg. An MRI revealed that I had ruptures in my L4 and L5 vertebrae which were impacting my sciatic nerve.

I became increasingly sedentary and soon found

***"I have learned how to safely work through the discomfort to improve myself not only physically, but also to become a better person, husband, father and instructor."***

myself out of shape and overweight. I was unhappy and depressed and decided to pull out of my graduate program not long after earning my Master's Degree.

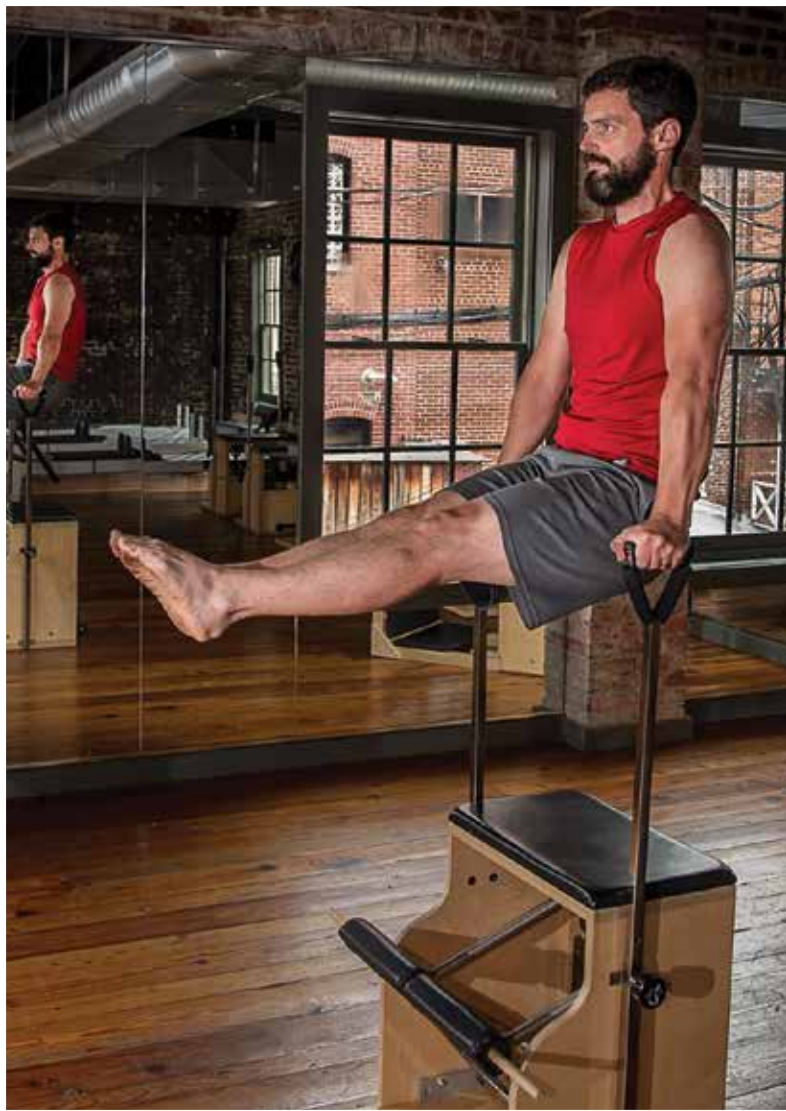
This was a low point in my life. I felt like a failure for leaving my graduate program, lived in daily pain, was unhappy with my physical appearance and terribly embarrassed of my ileostomy. I sought treatment for my pain from a number of doctors who readily prescribed me opioid pain medications. The medications masked the pain but did nothing to get to the root of the problem. My life began to spiral out of control as I developed a dependence on the medications and a growing tolerance to them, causing me to need more and more pills to make it through the day.

It was at this time that my sister Heidi began to convince me that I needed to try Pilates. Heidi is a Physical Therapist and Certified Pilates Instructor and was adamant that Pilates could help me with chronic back and nerve pain. I was hesitant at first--I knew little about Pilates but had plenty of misconceptions. However, I was also miserable and desperate for a change so I decided to take a chance.

Pilates is a form of movement re-education in which the exerciser learns to overcome faulty compensatory movement and stabilization patterns. The principal goals are to achieve efficient, functional movement, improved posture, core strength and flexibility.

My training started slow, focusing on coordinating my movements with my breath while maintaining core engagement. As the difficulty of the exercises progressed, I began to develop a better mind-body awareness, improved core stability, flexibility, full-body strength and coordination. Pilates began to alleviate not only my lower back pain, but also helped the pain caused by scar tissue. I felt like I had been given my life back. I was fit, healthy and pain free. For the first time, I no longer felt the need to hide my ostomy, I became comfortable talking to others about it and how it saved my life. I began to try other forms of exercise, I became trained in using the TRX, ran a full marathon and resumed my karate training, even competing in karate tournaments.

I enrolled in a 750-hour comprehensive Pilates certification course and am now a PMA® Certified Pilates Instructor. I developed a passion for studying and practicing Pilates and fitness and sharing that passion with others. I also became an ACE Certified Personal Trainer and continue to seek out new and effective exercise



modalities. After over ten years of teaching Pilates full-time, I started my own business. It feels amazing when my clients tell me they are in less pain, feel stronger, more flexible and in touch with their bodies.

Living and training with an ostomy can be difficult. While Pilates has completely freed me from sciatic nerve pain, my peroneal nerve can still cause me problems. Every few months, I wake up in severe pain. Despite this, I have learned how to safely and effectively work through the discomfort to improve myself not only physically, but also to become a better person, husband, father and instructor.

*Ryan Hodgkinson is the owner of Dynamic Pilates and Fitness, LLC, located in Washington, DC. Ryan is more than happy to share advice with his fellow ostomates. He can be reached at [www.DynamicPilatesDC.com](http://www.DynamicPilatesDC.com) or [Ryan@dynamicpilatesdc.com](mailto:Ryan@dynamicpilatesdc.com). 🐾*

# Short Bowel Syndrome

## Questions and answers about this serious gastrointestinal disorder

By United Ostomy Associations of America

Short Bowel Syndrome generally occurs when a large portion of the small intestine has been removed by surgery as a result of disease or injury. Some patients with an ostomy may also have what is known as Short Bowel Syndrome (sometimes called Short Gut Syndrome). It is important to talk to your doctor if you think you may have this condition.

### What Is Short Bowel Syndrome?

Short Bowel Syndrome (SBS) is a serious and chronic disorder. SBS is the result of physical loss and functional deficiency of portions of the small intestine (a.k.a. bowel), primarily due to surgical resection. Intestinal Failure, an associated condition, leads to the inability to absorb sufficient nutrients and fluid from your diet necessary for your health.

Common SBS causes in adults include Crohn's disease, vascular events, bariatric surgery complications and trauma. Common SBS causes in pediatrics include necrotizing enterocolitis, midgut volvulus, intestinal atresia, gastroschisis and malrotation.

### What are Common Symptoms?

If you have SBS, you may experience symptoms related to difficulty in absorbing the proper amounts of vitamins, minerals, nutrients, electrolytes and fluids. Adults with SBS often experience symptoms of malnutrition including poor skin and nails, weight loss and low energy. Infants and children may also fail to grow and develop. Symptoms vary according to the individual.

The following symptoms may occur at any time, but exacerbations indicate lack of adequate nutritional management:

- Diarrhea (various types) and high ostomy output. This major symptom is often accompanied by dehydration, malnutrition, weight loss and fatigue. Reasons vary with the type of resection and the amount and functionality of the remaining bowel.
- Abdominal pain and bloating
- Weight loss and malnutrition
- Dehydration
- Fatigue and weakness

### How is Short Bowel Syndrome Diagnosed?

The diagnosis of SBS is based on a combination

of a medical history, physical exam, laboratory tests, imaging exams and evaluation of operative reports.

### How is Short Bowel Syndrome Managed?

Management options for SBS are patient-specific and complex. A lot of factors determine the management, like the parts, length and function of remaining intestine after surgery. The management plan may change over time. The treating provider, often with the help of a registered dietitian or certified nutrition support clinician, will develop a plan that is best for each patient.

If you are a patient with SBS, you may have trouble absorbing the proper amount of nutrition and fluid from your diet. That's why the primary treatment goal is to ensure that you get the nutrition and fluid that you need (including proteins, carbohydrates, lipids, vitamins and minerals). At that same time, your provider will focus on symptom management using a variety of therapies.

Some patients who cannot maintain adequate nutrition and hydration by mouth may depend upon intravenous nutrition (IV) and hydration. This is commonly known as Parenteral Support (PS) or Parenteral Nutrition (PN). IV access needs to be established with a special IV that can remain in place for an extended period. PS or PN are often just administered at bedtime to allow patients normal activity during the daytime.

### What are Common Complications?

If you have SBS, you may also experience some common complications. Not everyone experiences complications. These are some common complications:

- Dehydration
- Weight loss and malnutrition
- Electrolyte abnormalities/imbbalances
- Vitamin and mineral deficiencies
- Acidosis
- Small bowel bacteria overgrowth
- Kidney stones
- Central line complications (such as infections)
- Gastric hypersecretion
- Kidney stones
- Bowel obstructions
- Intestinal failure associated liver disease (liver fibrosis)
- Gallstones
- Low bone mineral density

Again, it is important to talk to your doctor if you think you may have this condition. ☂





# YOU MATTER!

Know what to Expect and Know your Rights  
Ostomy and Continent Diversion Patient Bill of Rights:

## SIDE ONE

### THE OSTOMY AND CONTINENT DIVERSION PATIENT BILL OF RIGHTS

This Patient Bill of Rights is a tool produced by United Ostomy Associations of America for patients to advocate for their own care. To achieve a desirable quality of life, a person needing ostomy or continent diversion surgery must have access to high-quality care in all healthcare settings and should receive appropriate education and support to promote optimal adjustment to surgery.

Counseling and Care in the patient bill of rights should be provided by a trained medical professional such as a Certified WOC/OstomyNurse/OMS/OCA.

## SIDE TWO

Those needing ostomy/continent diversion surgery shall be involved in all phases of the surgical experience except in emergent situations and shall:

**Receive preoperative counseling to include:**

- Stoma site marking
- Discussion of care and impact on activities of daily living
- Emotional support

**Receive during the operative phase**

- A stoma that can be fit with a quality functioning pouching system

**Receive post-operative specialized nursing care to include:**

- Education on self-care of specific ostomy/continent type (i.e., emptying/changing pouch,

- care of skin, troubleshooting, dietary and fluid guidelines)
- Resources for obtaining supplies and connecting to community and industry support

**Receive for lifetime care ongoing support including:**

- Access to a medical professional trained in ostomy and continent diversion care in the outpatient setting
- Re-evaluation as needed from changes caused by aging and change of medical status

Details: [www.ostomy.org](http://www.ostomy.org)

FOLD LINE

For more details about these rights visit [www.ostomy.org](http://www.ostomy.org)

If you believe your rights are not being met, speak up.

# BE A FORCE FOR CHANGE!

# Basic Urostomy Care

## Learning the ins and outs of basic stoma care and pouch management

By Joy Boarini, MSN, WOC  
Clinical Education Manager,  
Hollister Incorporated

If you are about to have — or have recently had — ostomy surgery, it is important to remember that you are not alone. Every year, thousands of people undergo ostomy surgery and it is natural to have questions and concerns.

There are three basic types of ostomies – a colostomy, an ileostomy and a urostomy. Although there are many similarities between these ostomies, it is what makes them different that is crucial to proper care and to avoiding possible complications. It is important for you to know what kind of ostomy you have. This article will focus on the unique aspects of a urostomy.

### Overview

A urostomy is an ostomy, or surgical opening, created to drain urine. A urostomy may also be called an ileal conduit and is one type of urinary diversion. It allows urine to flow out of the body after the bladder has been removed or bypassed. Because there is no sphincter muscle, there is no control over when to urinate. Instead, an external pouching system collects urine.

One specific and common type of surgical construction is called an ileal conduit. When you have an ileal conduit, your stoma drains not only urine, but also various amounts of mucus.

Reasons for the creation of a urostomy may include bladder cancer, spinal cord injury, bladder malfunction and spina bifida. It is estimated that approximately 38,000 urostomy surgeries are done each year in the United States.

If you have not yet had your surgery, determining where the stoma (a surgically created opening) will be placed on your abdomen is a very important part of the preoperative preparation. Quite often, an ileal



Photo courtesy of Coloplast

conduit stoma is located on the abdomen just below your waist and to the right of your navel (belly button). Before surgery, your ostomy nurse and your surgeon can help determine the best location for your stoma. Ideally, the stoma should be placed on a smooth skin surface and should be located where you can see it easily and take care of it yourself.

### After Surgery

After surgery, you will have a pouch which will collect urine. Initially, the urine may be tinged with blood, this is normal. As time goes on, it

should lighten up and the color should be very similar to the color your urine used to be. After surgery, there may be stents or small tubes in the stoma. These are temporary (days to weeks) and will be removed by your surgeon or ostomy nurse. In the hospital, the staff will use a pouching system that allows them to best manage and monitor your care following surgery. Here are some common pouching system features and practices that follow urostomy surgery:

- Your pouch will be transparent or clear so that your doctors and nurses can observe your urine and the color of your stoma.
- Hospitals will generally use a product that has a cut-to-fit or shape-to-fit skin barrier. This allows the staff to customize the opening so that your skin is protected from contact with the urine.
- The pouching system used may be a one-piece or a two-piece — at this early point in your recovery, it does not really matter. What is important is that you get a secure seal and time to recover from your operation.
- During your hospital stay, your pouch may be connected to a urinary drainage bag. This bag has tubing and a large capacity to make it possible for the nursing staff to accurately measure your urine output and empty your pouch without disturbing you as often.

- A urostomy pouch typically has a spout or tap at the bottom. This is unique to a pouch which needs to drain urine. The spout makes it easier to empty urine and is different from drainable pouches used for colostomies and ileostomies.

- A urostomy pouch is also unique from other ostomy products in that it typically has anti-reflux or no-flow back valves. These are not easy to see, but are an important, built-in feature of most urostomy pouches. When you lie down or recline, these valves help prevent urine from flowing back up onto your stoma and skin barrier to minimize contact with urine on your skin.

## When You Go Home

After discharge from the hospital, you will still need time for recovery. In addition to your ostomy, you will have incision lines and possibly a drain and/or stents. You will need to follow your physician's orders as it relates to activity, medications, diet and follow-up.

Since your hospital stay may be short, it is not uncommon to have a home care nurse visit you in your home to assist with learning to care for your stoma. These nurses may not have the same level of expertise that your WOC nurse has when it comes to ostomy care. However, they can assist you and your family as you learn to become more comfortable and proficient in your skills and self-care.

In addition, there are also services provided by ostomy product manufacturers that can help with your transition from hospital to home. They can assist you by answering product and lifestyle-related questions, providing basic educational materials, helping you find a pouching system that works for you, and assisting you with finding an in-network supplier who will mail your supplies to you. All of these can be valuable services in addition to what you receive from your health care team.

As time goes by, you will become more confident and your pouch changes will take less time. You will start to learn what works best for you. See the sidebar this page for suggestions for your routine urostomy care.

Eventually, you will be independent in your ostomy care. During this time, you will also want to find the best pouching system for you. Your needs will change over time and the pouching system that worked for you immediately after your discharge from the hospital may not be the best pouching system for you later.

Your stoma size may change over the first six to eight weeks after surgery. For that reason, you may want to continue to use a cut-to-fit skin barrier. However, it is important to continue to change the size you cut or shape your skin barrier to, so that all your skin is

## Routine Urostomy Care

- Empty your pouch when one-third to one-half full.
- Change your skin barrier every 3-7 days.
- You should not experience frequent leakage of your pouch seal. If you do, consult a WOC Nurse.
- Soap is not needed to clean the peristomal skin. If you use soap, make sure it does not contain any oils or lotions that can interfere with adhesives.
- Always rinse your skin and dry completely before you adhere the new pouch.
- After you apply your skin barrier, hold it in place against your skin for about one minute. This will help to activate the adhesive.
- You can shower, bathe, or swim with your ostomy after you are cleared by your physician.
- If you are using a bedside collection bag, clean it daily with a recommended solution to help minimize odor, crystal formation, and bacteria.

covered and protected. For more help on choosing the right pouching system, see page 60.

- In the hospital, a clear pouch was likely used by the hospital staff to help them monitor your progress. Now that you are home, you may want to consider using a pouch that is beige to help disguise the pouch contents. It's your choice.

- At home, you may still want to use a urinary drainage bag or container at night. These help to ensure that you do not have to get up in the middle of the night to empty your pouch. There are several different styles and options. Once you select one, it is important to clean it daily to help avoid odor and possible infection. There are commercially available urinary cleaners and decrystallizers which are safe and easy to use. A 50:50 solution of water and white vinegar can also be used. Remember, these products are for the collection bag not your ostomy pouch.

- Once you become more active, you may also find that ostomy accessories are needed to help improve the pouch seal to your skin. For urostomies, barrier rings are typically preferred over barrier paste because they tend to hold up better to urine.

Many other things will be similar to what you knew before surgery. There are typically very few dietary alterations that are needed once you recover. To keep

*continued on page 61*

# Urostomy Pouching Systems

## Understanding the many management products available for urostomates

By Leslie Washuta, RN, BSN, CWON  
Certified Wound/Ostomy Nurse

This article is intended to help urostomates understand the basic product choices and specific reasons for choosing each type or style of product. First, an “appliance” simply refers to the pouching system at the site of your stoma. It may be simple or complex, disposable or re-usable, one-piece or two-pieces and have a whole host of features, materials and designs that make it unique. Ostomy pouching systems are a very personalized product: what works for others may not work for you. Also consider that as you age, your body will change and possibly the “landscape” around your stoma, so there may be benefits to trying new products. Manufacturers are constantly updating and improving their products as well.

### Common Urostomy Products

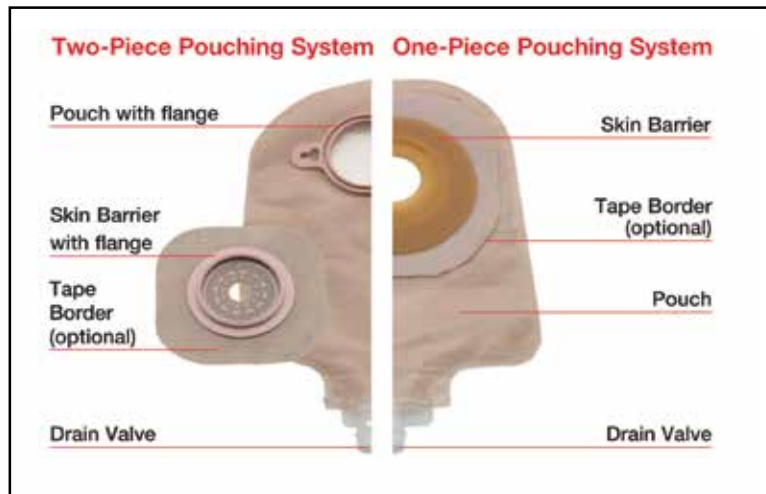
**Skin Barrier (Wafer):** This is the product that is used to protect your skin and to act as a “barrier” to injury from the urine emitted from the stoma. “Wafer” and “flange” both fall under this category.

Essentially, a wafer is made to resist the effects of urine and generally will have both adhesive and non-adhesive sides. The adhesive side, of course, is intended to adhere to your skin surrounding your stoma. The non-adhesive side faces outward and often provides a mechanism for attaching a pouch, such as a plastic ring.

Wafers come in many sizes, styles and even rigidity levels. Wafers are available in both a standard formula and an “extended wear” formula. The latter is usually the more appropriate choice for people with urostomies as it tends to hold up better with urinary output.

Many wafers are flat; however, if your stoma is flat or sits below skin level, a wafer with “convexity” is often the better choice for you. A convex wafer is manufactured with a rounded contour on the adhesive side to

make better contact with your skin and help the stoma protrude, resulting in a better fit and more satisfactory wear time than you might get from a flat wafer. Convex inserts, barrier rings and paste can be added to flat wafers to attain convexity.



And, finally, wafers can be purchased as a “cut-to-fit” style which requires you to cut out the opening, and which may be your better choice if your stoma is more oval-shaped than round. Or, if your stoma is relatively round, wafers can be purchased already cut to size (pre-cut). You might find a distributor offering to cut irregular-shaped stoma openings for customers

who have difficulty with manual dexterity or vision limitations. If this is your situation, inquire.

A well-fitted wafer should remain in place at least three days without leakage. If it does not, you may need to consider using one or several of the accessories described later in this article.

**Pouch:** The ostomy pouch is designed to collect the outflow of urine from the stoma until it is convenient for you to empty it. The basic urostomy pouch, which snaps or locks onto the wafer by adjoining the rings located on each, will have several features that are different from other kinds of ostomy pouches.

Because your output from your stoma is liquid, a “spouted” outlet rather than a wide tail will be the proper choice for you. This will allow you to empty the pouch and re-close it easily. Another feature unique to urostomy pouches is the presence of the “anti-reflux” mechanism which is built into the inside of the pouch.

This mechanism keeps the urine from washing back up over the stoma once it has flowed to the bottom of the pouch, thereby helping to prevent wafer erosion and skin irritation from repeated urine contact.

Occasionally, mucus from your stoma may back up and get caught in this mechanism and is difficult to wash out; I would advise discarding the pouch and using a new one rather than trying to wash out the worn

pouch, for hygienic reasons.

For the patient with skin allergies to various products or seeking an alternative appliance: you might consider trying the one-piece non-adhesive urostomy set now being distributed by Nu-Hope. Called the EV Non-Adhesive System (formerly EHOB and VPI), this is a completely re-usable system for urine collection and drainage which stays in place with a special non-adhesive silicone ring and belt. It is a truly unique product.

**One-Piece and Two-Piece:** The above two products (the skin barrier/wafer and the pouch) are described separately as many appliances are produced in this manner and are often the more common style of appliance for all ostomies.

This is called a “two-piece appliance.” Of equal importance is noting that virtually all ostomy product manufacturers also offer appliance models which combine these two products together into what is termed a “one-piece appliance.”

There are advantages to both styles: a two-piece appliance can use a “mix and match” approach, combining a specific wafer (flat or convex) with several difference styles of pouches (opaque or transparent), are applied separately and can be removed separately; this would allow you to put on a new or clean pouch halfway through your expected wafer wear-time. A one-piece goes on and off all as one unit, so there is a little less handling required, which may be easier for those with limited manual dexterity. See page 30.

**Overnight Drainage Bag:** This item is purchased separately and used during the nighttime/sleeping hours. Urine will flow through your attached pouch to the larger bag hanging from or positioned near the side of your bed. You connect up at bedtime, remembering to place your pouch spout in the “open” position to allow the urine to flow into the drainage bag from your pouch. In the morning, simply detach, close your pouch spout, and clean the larger bag.

Special appliance cleansing solutions are marketed by ostomy suppliers to clean and deodorize these overnight drainage systems to help keep them fresh. A 50:50 solution of water and white vinegar can also be used.

Occasionally, a person with a urostomy may want to use a “leg bag” drainage system during waking hours if they will not have ready access to a bathroom over a number of hours, but this generally is not “the norm.”

## Final Thoughts

There are many ostomy product manufacturers, some of which make re-useable and customized products for the most difficult and challenging ostomy problems as well as for standard ostomy use. Good luck in your search for the best system for your needs. ☂

## Basic Urostomy Care from page 59

your kidneys functioning properly and to help prevent urinary tract infections, you should drink plenty of water. Beets may cause your urine to turn a reddish color, but this is usually temporary. Asparagus, seafood, and some dietary supplements may cause your urine to have a strong odor. Of course, each person’s needs are different. Always check with your doctor regarding any questions on diet and fluid intake.

Once you have recovered from surgery, your urostomy should not limit you. You should be able to return to work or travel just about anywhere. When you travel, take your urostomy supplies with you. Take more than you think you will need and remember that supplies may be different in other countries.

## Follow-Up Care

Routine check-ups are a must after ostomy surgery. Your surgeon will likely want to see you again to follow your progress and make sure you are healing. Remember, if you had stents in your stoma when you were in the hospital, ask your surgeon about removing them at your first visit if they are still there.

Check in periodically with your ostomy nurse. They may want to see you as a part of the routine care they provide. If you have any issues with your pouching system or skin, be sure to call and notify them.

## Potential Problems

No matter what type of surgery you have had, there is always the possibility for you to have a problem which can range from mild to severe. The key is to report anything unusual before it becomes more serious.

You should call your ostomy nurse if you notice any of the following problems: signs of a urinary tract infection (dark, cloudy, strong-smelling urine; back pain; nausea or vomiting; fever; loss of appetite; skin irritation around your stoma (inspect your skin with each pouch change); recurrent leaks of your pouching system seal; excessive bleeding of your stoma (a small amount of bleeding is normal); if your stoma starts to get longer (prolapses); a warty, discoloration of the skin around your stoma; and urine crystals on or around your stoma.

## Resources

There are many resources available like United Ostomy Associations of America (UOAA) – [www.ostomy.org](http://www.ostomy.org), American Bladder Cancer Society, educational booklets and online information. Be sure you are looking at information specific to urostomies and that you are visiting safe and reputable websites. ☂

# Ballroom Dance

## Ostomate's first love is her best therapy during cancer treatments

By Jadranka Vrsalovic Carevic

I moved from Barcelona to New York City sixteen years ago to marry Manel, my amazing husband, who is an artist. I organize cultural events and deal with creative and interesting people for a living. I have a healthy and happy life – I just happen to have gotten cancer. Three cancers, to be exact. Sometimes, I think I am collecting cancers as someone else might collect stamps. But we all get what we get in life, the only thing we can do is make the best out of it.

***“I am not letting a stupid cancer stand in my way! I am going to compete in a ballroom competition and I am going to win!”***

### Life-Changing Experience

When I was diagnosed with breast cancer in 2012, someone told me it was going to be a life-changing experience. Ironically, there was nothing I really wanted to change in my life.

I was crazy about ballroom dancing when I was a teenager. My friends used to say to make me smile, you had to take me to the sea, dancing, or to the local Chinese restaurant. I have outgrown Chinese food, but smelling the sea and dancing make me smile.

After the diagnosis, I started ballroom dancing again. I began tentatively and then grew more and more obsessed with it! At the dance studio, I could forget about the racket of the city, the problems at work and my health issues. Hearing the music and exchanging a few words with my fellow dancers and practicing my steps would completely change my mood. Everything was good again.

In September of 2016, out of the blue, there was blood in my urine. By the evening it was gone. The day after, my urine was tinted red again, so I called my doctor. After a few weeks, I was diagnosed with bladder cancer.

### A Long Ride

It was a shock, and a bad one. A whole new life opened up in front of me: resections, BCG treatments - to which I reacted, quite untypically, with very painful

cramps and malaise. The cancer would come back and then more resections and more treatments. Then it came back again. I was in it for a long ride.

I was in the best possible medical hands at Memorial Sloan Kettering Cancer Center in New York. Fortunately, I had my incredible husband and my family and friends and colleagues at work at my side for all the support I needed, but it was still physically and emotionally exhausting. While mentally I can deal with the illness, physical pain really brings me down. There

were moments I couldn't stand people asking me how I was. One day, a smiling, happy homeless man greeted me with, "Hi. How are you?" I started crying and couldn't stop. I cried quite a bit in those days.

The cancer also made me very mad. Mad at life, at destiny, at the pain I was experiencing. So I said to myself, "This is not going to stop me. I am not letting a stupid cancer stand in my way! I am going to compete in a ballroom competition and I am going to win!"

And that is exactly what I did. Between work and hospital visits and dance lessons, I got a beautiful green gown. In January of 2017, four months after the diagnosis, I danced at my first competition, Golden Star, with my teacher. We won! It was an incredible experience. I am not a competitive person and any kind of public exposure normally makes me very nervous, but it didn't matter. Nothing mattered. I was someone else. I could do it and I could win. I could win the cancer too!

### Dancing in the Corridors

I did one more competition, Manhattan Ballroom Championship, before I was told my cancer was back and spreading. The risk of it going deeper was high. My amazing urologist, Dr. Bochner at MSKCC to whom I owe my life, my husband and I made the decision to remove my bladder.

The idea was to try to create a neobladder, but my nasty little cancer had other plans. I woke up from the surgery with no bladder and a urostomy pouch. I was very weak after the surgery, but as soon as I could, I was walking around hospital. I even danced a little through the corridors. After a week, I was released

home. My husband, Manel, and I learned how to change the pouch. He did it for me in the beginning when I was too weak and too scared to do it myself. He never complained. He comforted me at the sight of my new body. He loved me the way I had been and the way I was now. He is the biggest support in my life.

During convalescence, I couldn't focus on reading or listening to music, so I built puzzles: huge, 1000-piece puzzles that would keep my thoughts away for hours. I also called manufacturers and requested samples of their flattest urostomy pouches thinking it had to be invisible under my ballroom dress! It was like a game. I was dying to be able to start dancing again.

My doctor said I was to avoid any strenuous physical activity for six weeks after the surgery. On the very first day after those six weeks, I was back on the dance floor. The setback had been huge, though. I had no stamina. My muscles wouldn't hold me. I was weak and dizzy all the time. It took me weeks to be able to dance a full lesson without interruptions because I needed to rest.

### Post-War Depression

It was hard to accept that everything that I had achieved was gone. All that hard work, lost. It got to me mentally. It was a little bit like the war. It was much easier to be in the war than the post-war. During the war, you didn't think, you just did what you had to do to save your life and that was it. The depression would come after the war. In this case, it came after I did my first checkups and got the good news. All the results had come back negative. No cancer left. No enemy to fight anymore. And now, what?

Thomas, my teacher, decided we would do another



*Jadranka Vrsalovic Carevic and Thomas Papkala at the 2017 Golden Star Dancesport Championship.*

competition. He signed us up for King's Ball, four months to the day after my big surgery. The way he put it, it was going to make me feel alive again. At that point, I was not feeling alive or excited or happy. Not even dancing made me smile and that made me even more sad.

### The Best Therapy

Dancing was always my best therapy. It gave me strength throughout the illness, but I had lost that too. I knew it was important to dance and compete, but I was very nervous about my pouching system. A friend made a sleeve to hold my leg bag to my thigh. I altered my underwear and panties to accommodate everything. It all worked out well. We won and I marked another small victory. I was back on track.

Since then, my life has been checkups every three months with my fingers tightly crossed as I competed and won more medals. I went back to traveling and back to everything until I was diagnosed with a third cancer! This time a slow-growing lymphoma (cancer of the lymph system).

Just a couple of weeks after finishing radiation therapy, the three of us were heading to Orlando to compete in the U.S. Nationals!

I had been saying for years, "Just you wait. You will see. One day I will win Nationals." I guess what I wanted to say was, one day I will become a really very good dancer, so good that I could even win Nationals...

### More Than Happy

And instead of winning, we placed second! Now, sincerely, given the circumstances, I am more than happy with the silver medal! After everything I had been through, it is an excellent result. But, the idea was to win. So I will have to go back and try again. I haven't achieved my goal, but I will. One day. Just you wait. ☺

# Continent Bowel Diversions

## Innovative surgical procedures designed to achieve continence

By Gregg I. Shore MD, FASCS, FASCRS

Prior to 1980, the only surgical operation to cure ulcerative colitis and familial polyposis was total proctocolectomy (complete removal of the colon and the rectum) with permanent end (Brooke) ileostomy.

Despite the challenges of living with a conventional ileostomy, most people with a well-constructed ostomy are able to live normal, healthy and active lives.

Over the past several decades, new surgical alternatives have been developed and refined that give patients alternatives to a lifelong conventional ostomy. These alternative procedures include continent ileostomies, pelvic pouches and "pull-throughs." Each category has several variations.

Continent ileostomies include the Kock pouch, T-pouch and Barnett Continent Intestinal Reservoir, (BCIR). Pelvic pouches are also called ileoanal pouch anastomosis (IAPA) and further described by the shape of the pouch: j-pouch (the most common), s-pouch, w-pouch. Pull-through procedures involve removing a section of intestine and reconnecting the bowel without creating a pouch. Both IAPA and pull-throughs allow for a normal route of evacuation.

### Internal Pouches

A continent ileostomy is a reservoir constructed from the small intestine that is able to store a significant amount of fecal waste. The Kock pouch and BCIR are constructed from small intestine with an exit stoma for feces flush with skin and below the belt line. The main candidates are patients who have had their anal sphincter muscles removed and currently have an ostomy or have poorly functioning anal sphincter muscles and are not candidates for a pelvic pouch or have a pelvic pouch that doesn't work adequately.

The ileoanal pouch anastomosis (IAPA) is also a reservoir constructed from the small bowel, but it is connected to the anus and sphincter muscles directly and exit of feces occurs through one's natural orifice. It is also commonly referred to as a "j-pouch" as the reservoir made of small intestine resembles the letter "j."

### History

The continent ileostomy was first pioneered by Dr. Nils Kock, a Swedish surgeon, in 1969 and has since undergone many changes and improvements that have made it very reliable and a life-changing option.

Since its introduction by Dr. Kock, the continent ileostomy is currently offered by only a limited number of centers in the USA and around the world, as it has largely been replaced by the IAPA, specifically the j-pouch procedure.

Results from these surgical centers are quite good and overall patient satisfaction is very high. Modifications over the years have included improving the length of the valve and surgical technique that keep the valve from slipping. The creation by the late Dr. William Barnett of the "living collar" has decreased slippage to less than 10%. A slipped valve remains one of the most common complications of the continent ileostomy.

Reduction of complications is also shown when the surgery is performed by a board certified colon-rectal surgeon who specializes in pouch and continent reservoir surgery.

### Candidates

The first step is to discuss it with your surgeon. The primary criteria are an ileostomy and both the rectum and anus have been removed. A minimum of 14 feet of small bowel is recommended to minimize the potential for short bowel syndrome if the continent reservoir fails and needs to be removed. Morbid obesity is a contra-indication due to the high incidence of valve dysfunction due to thick abdominal wall fat.

A very select group of patients with Crohn's disease may be considered. If you are not a candidate for a pelvic pouch or have one that has failed, a continent ileostomy is currently the only alternative to have an appliance-free life.

Patients with a colostomy frequently ask if they are candidates. The pouch is made from small bowel, so any remaining large intestine would have to be removed. If only a couple of feet remain, this is not an issue. If the

***"Continent bowel diversions can be demanding. Patients must be highly motivated and realize there is a significant amount of risk that may require further surgery to correct potential problems."***





*Left: Figure A, continent ileostomy – a Barnett Continent Internal Reservoir looks similar. Figure B, the “j-pouch” variation of an ileoanal pouch anastomosis.*

majority of your colon is intact, this is a radical surgical option to consider. Only after extensive discussion and the concurrence of your primary doctors should this option be considered.

### **Continent Ileostomies**

Approximately two feet of small bowel is used to create the continent reservoir (see figure A above). The stoma is flush on the right side, usually parallel with the hip bone.

Postoperatively, the continent reservoir is allowed to rest by an indwelling catheter for two-to-three weeks. This is to allow the new reservoir suture line to heal properly to prevent leakage problems. Some patients will need to be on suction in the hospital for several weeks, but others may be discharged within a week with a catheter sutured to the skin or held in place with a fixation device and connected to a leg bag.

After two to six weeks, “self intubation” begins at two-hour intervals, eventually working up to three to four times a day. Occasional irrigation of the reservoir with potable water may be needed if the contents are too thick to drain easily through the catheter. A small pad is needed to cover the stoma to absorb mucous drainage that occurs periodically. Change in diet is minimal provided you chew your food well and increase your fluid intake to keep your stool a thin consistency.

There are very few restrictions in the life style with a continent ostomy, although vigorous physical activity should only be performed with an empty pouch. Direct trauma to the pouch may cause problems, especially if the pouch is full.

### **Patient Commitment**

Continent bowel diversions can be demanding, both on the surgeons who need to contribute a high level of skill and commitment to long-term care and on the patient. Therefore, it is best to consult board certified colon-rectal surgeons who are comfortable with all surgical options and have significant experience with the creation and care of continent procedures.

Patients must be highly motivated and realize there is a significant amount of risk that may require further surgery to correct potential problems. Like all surgeries, continent ileostomies have pros and cons. The obvious advantage is an appliance-free life. The cost of supplies is significantly reduced compared to a conventional ileostomy. For those who have problems with their ileostomy, it can be a new-found freedom.

The disadvantages are complications that will require additional surgery to repair; these include slipped valve, intestinal fistula and pouchitis. Complications not unique to this type of surgery would include bleeding, intestinal obstruction and peristomal hernias.

## Complications

1: Pouchitis: This refers to an inflammation of the pouch. It is generally a condition wherein the patient will develop abnormal cramps, feeling poorly, frequent bowel movements and possible fever. Treatment depends on severity of the condition:

- A) Mild – diet change, antispasmodics and anti-diarrheal medication.
- B) Moderate – antibiotics or probiotics.
- C) Severe – hospitalization, bowel rest and IV antibiotics; possible steroid therapy. Pouch removal may be required.

2. Stoma Stenosis: This is the narrowing of the stoma that may occur during healing. A simple outpatient surgery can repair this.

3. Slipped valve: The valve is coming apart and returning to its original state. When this occurs, it will become shorter, the access segment will appear longer and not straight. Therefore, intubations will become difficult and the pouch will leak intestinal waste through the stoma. This will require surgery to repair.

4. Fistula: An abnormal sinus with the gastrointestinal tract. Treatment depends on place of occurrence: TPN (no eating by mouth), bowel rest and surgery.

## Pelvic Pouches

In the 1940s and 1950s, procedures that connected the small intestine directly to the anal sphincter often resulted in severe fecal urgency (the sudden, unstopable urge to defecate), frequency and perianal skin breakdown. In the 1980s, pelvic pouches evolved from the continent ileostomy. By allowing passage of stool through the anal orifice, the procedures are the closest to the natural way of eliminating fecal waste.

## Construction

The pelvic pouch also requires the usage of 8 to 18 inches of the small bowel to construct a substitute rectum. Once the colon and rectum are removed, preserving only the anus, the small intestines have minimal capacity to store stool. To make a functional reservoir, the small bowel is folded on itself and the adjacent bowel loops sewn or stapled together.

The operation is performed in either one, two or three stages, depending on the health of the patient and the health of the intestines. Usually, a temporary loop ileostomy is used to allow proper healing of the pouch for approximately three months.

## Candidates

The j-pouch is the current “gold standard” and first choice procedure to offer those patients who have had medically refractory ulcerative colitis or familial

adenomatous polyposis syndrome. This procedure can only be performed on patients who still have their anal canal and properly functioning sphincters.

Sometimes, during surgery, it is determined that the pelvic pouch cannot be connected to the anus due to inadequate length of the small intestine. In these unusual situations, a continent ileostomy can be immediately created so the patient does not have to undergo a subsequent operation or have an unexpected permanent ileostomy.

Those with other medical conditions that make anesthesia and surgery excessively risky or have known small-bowel Crohn’s disease are not viable candidates.

## After Surgery

Immediately post-operatively, it is common to experience urgency, frequency and slight bowel incontinence. Once the pouch has healed and enlarged, approximately three to eight bowel movements a day can be expected. The average is four to six times a day. There are very few dietary or activity restrictions.

## Pros and Cons

The main advantage of an ileoanal pouch is the ability to evacuate stool in the usual fashion through the anus. There is no need for supplies or catheters.

Some patients experience “butt burn” after surgery. This is due to high stool frequency and slight incontinence. This subsides after the initial adjustment period. A zinc-oxide containing protective paste can help minimize this initial discomfort. Like the continent ileostomy, pouchitis is the most common complication. Bowel obstruction, pelvic infection, fistula and stenosis are also complications of this surgery.

## Complications

1. Pouchitis – urgency, frequency, painful straining, bleeding and incontinence. See continent ileostomy for treatment options.

2. Bowel obstruction – nausea, vomiting, bloated and unable to pass stool. Early in recovery, this can be due to food not chewed properly. Later, it is caused by adhesions that kink the small intestines. The majority of obstruction can be resolved without surgery.

3. Pelvic infection – fever, chills, lack of energy. The cause is a result of a leak where the bowel is newly connected. This occurs in about 6% of patients and can be treated with antibiotics or by placing a drain in the site that is infected.

4. Stenosis – incomplete emptying of the bowel or frequent, urgent bowel movements. It is rarely a significant problem and can resolve by gentle dilation of the anastomosis digitally or with specialized dilators.

## Summary

Patient satisfaction and quality of life scores with ileal internal reservoir surgery have been high. As the operations continue to evolve, patients are also having fewer complications and better function over the long term. Many of the problems experienced early in the development of these procedures have been greatly reduced or eliminated.

Psychosocial adjustment to the reservoirs depends on many things, such as whether complications occur, the ability to resume a normal lifestyle and the expertise of the health care team in providing routine care, education and emotional support in managing any complications that may develop.

The ability to return to a normal, healthy life without an external appliance or without urgency and rectal bleeding from ulcerative colitis, can help achieve a sense of emotional well-being. There is usually a great sense of relief after these procedures and even elation at having been given a second chance at life because the patient's perceived health has greatly improved.

The need for surgery and the choice of operation are major decisions. Patients are encouraged to learn as much as possible about their disease and the treatment options available. ☞

**OSTOMY ARMOR** ostomyarmor.com  
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info@ostomyarmor.com

**ALL SIZES STOMAS HERNIAS**

**ANY LIFESTYLE**

**Stoma Protection. Leak Control.**

The advertisement features a blue and white color scheme. At the top left is the 'OSTOMY ARMOR' logo, which consists of a shield with a cross inside. To the right of the logo is the company's website, phone number, and email address. Below this is the text 'ALL SIZES STOMAS HERNIAS' in large, bold, black letters. Underneath that is the phrase 'ANY LIFESTYLE' in a similar font. The central part of the ad contains three small images: a man in a dark shirt standing next to a yellow and black car, a group of people walking on a beach, and a man in a green shirt working out on a gym machine. At the bottom of the ad, there is a large image of a white and blue Ostomy Armor stoma protection device, and next to it is a box of 'OSTOMY ARMOR WIPES' and a single wipe. The text 'Stoma Protection. Leak Control.' is written at the bottom of the ad.

## Peristomal Skin Products from page 35

is often better to use an adhesive remover rather than scrubbing and possibly abrading your skin. They can also be helpful when removing the adhesive if it is adhering too much to your skin. The solvent can break the adhesive bond and may help keep your skin from tearing when you remove the barrier or tape.

After using an adhesive remover, it is important to completely clean and dry your skin. This will help the next pouching system to adhere more securely.

There are other wipes that may be used on the peristomal skin for cleaning purposes. Be sure you know if the wipe you are using is intended for use under an ostomy skin barrier. Some of these products contain ingredients (e.g., lanolin), which may interfere with adhesion. Alcohol wipes for routine cleansing are not recommended as they tend to cause excessive drying of the skin.

Liquid adhesives can be used to increase the bond between the skin surface and the skin barrier. These products are especially helpful when pouch failure is due to the separation of the skin barrier from the skin (e.g., limited skin surface area, challenging contours). Various delivery methods are available including sprays, and brush on applications. Some of these products are

applied to the skin, and others to the skin barrier so refer to specific product instructions for use.

## Conclusion

Today there are many products available for peristomal skin care. Sometimes it can be overwhelming. You want to be sure you are well-informed not only about accessories available for ostomy care, but also about how to use them correctly. Most ostomy accessories are covered by Medicare and insurance providers.\*

If you have questions, there are many resources available to you. You can consult with your WOC Nurse, your ostomy product manufacturer, and/or your product supplier. Remember an ostomy accessory should be something that provides a benefit to your life with an ostomy. *The information presented in this article relates to the proper use, care, and application of Hollister® brand ostomy accessories only. For information on the correct usage of other ostomy supplies, please contact an ostomy nurse or the manufacturer.*

*\*Coverage policies and guidelines are complex, and can vary from one carrier or region to another, and are updated frequently. There is no guarantee of coverage or payment for any particular accessory. ☞*

# Continent Urinary Diversions

## Living with the two most popular internal pouches for bladder diversions

By Roni Olsen, Ostomy Association of Metro Denver

During the second revision of my husband Ben's ileal conduit, it was removed and replaced with an internal continent Kock pouch with an abdominal stoma. He fought his way back to enjoying a busy and physically active lifestyle.

As a result, we learned a great deal about urostomies in general and the pros and cons of the three different types of urinary diversions: an ileal conduit that requires an external pouch, an internal pouch that requires convenient catheterization through an abdominal stoma, and the internal continent pouch/neobladder that is reconnected to the urethra to provide near-normal urination.

We also learned a urinary diversion provides a second chance at life for those whose urinary bladders must be removed. Understanding the critical role of ostomy surgery is essential to both the physical and psychological adjustment to the altered body function and diminished self-esteem that routinely accompany most ostomy surgeries.

As body strength is regained, dealing with an ostomy actually becomes routine, but the psychological adjustment often takes a much longer period. Some people will have the support of a caring family and/or friends to help them through the process, while others less fortunate may have to fight the uphill battle alone. Whatever the circumstance, each urostomate's attitude is ultimately the key to life with a urinary diversion. An ostomy need not permanently limit a person's activities, abilities, interests or horizons. The urostomate in tune with life will understand that each day is to be treasured and not wasted.

### Internal Continent Pouches

There are two types of internal continent urinary pouches (also called reservoirs): the internal pouch with an abdominal stoma and the internal pouch that is reconnected to the urethra (neobladder). These internal continent urinary pouches with abdominal stomas are similar to a normal urinary bladder, except they are not connected to the urethra. Instead, they are connected to an abdominal stoma located on the abdomen. These pouches are emptied by patient self-catheterization through the stoma. Internal continent pouches include the Kock pouch and the Indiana pouch, and several

variations, including the Mainz, Miami, Florida, Studer, and Mitrofanoff pouches. The Indiana is now the most common catheterizable urinary diversion.

### Kock Pouches

The Kock continent urinary pouch (pronounced "coke") is made from approximately two feet of ileum. A valve is created at each end of the pouch. The ureters are connected to the internal valve which prevents reflux to the kidneys and the end of the other valve is brought to the abdominal surface to form a small continent stoma. The Kock pouch is emptied by inserting a flexible silicone catheter with a coude' tip ('elbow' or angled tip) into the stoma four to eight times a day.

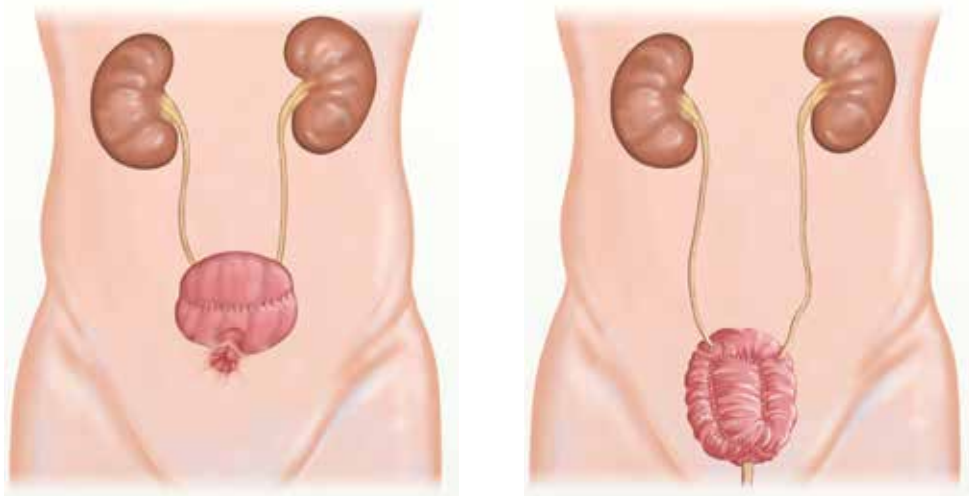
### Indiana Pouch

The Indiana-type pouches are easier to construct than the Kock pouch, but they hold a smaller volume of urine. Typically, segments of both small and large intestine are used to form these pouches and usually the ileo-cecal valve (the valve between the large and small intestine) becomes the continence valve. Stomas for these pouches are frequently placed in the belly-button, and catheterizing is usually required every four to six hours. In some cases, patients are also instructed to irrigate their pouches to help remove mucus, generally a few times a week.

Any feeling of fullness or discomfort in any of these pouches, or feeling of cramping or nausea, usually means the pouch needs to be emptied. Excessive fluid intake at any time may result in the need for more frequent catheterization. Regardless of the time between catheterizations, these feelings should never be ignored. Catheterization of the stoma is convenient, easy, painless and maintenance is minimal. Since they don't leak, they don't require an external appliance and their stomas can be made almost flush with the skin.

### Catheterization of the Internal Continent Pouch

Techniques for catheterization will vary slightly because the shape and angle of the stoma or nipple valve and depth of the abdominal wall varies from patient to patient. Fortunately, a wide variety of catheters are available to accommodate these differences. Usually, the patient is taught to catheterize the pouch in



*Left: Internal continent pouch.  
Right: neobladder.*

both a sitting and standing position and is also encouraged to relax the abdomen. In either case, relaxation of the abdomen is far easier said than done during the first few weeks of self-catheterization. Although the process of poking a drain tube into the abdomen seems like an outrageously bizarre task at first, catheterization is actually simple, quick and painless. It rather quickly becomes routine.

Catheterization of the continent pouch is not a sterile procedure; at best it is only as clean as the local tap water. The procedure works best when two hands are used to hold and manipulate the catheter; therefore, hands should be washed with soap and water prior. Keep all supplies in carry-on luggage when traveling and do not leave supplies in a hot car or any other place that is overly warm. In most cases, a small, moisture-proof pad needs to be worn over the stoma to absorb normal stomal secretions.

Catheters fit easily into sandwich bags as well as a pocket, purse, backpack, or glove compartment and at least one clean catheter should always be available.

Catheters should be thoroughly rinsed inside and out with tap water, then air dried before re-use. If traveling abroad, bottled water is advised. People with catheterizable urinary pouches are advised to wear a medical alert bracelet or necklace in case they need emergency attention. Again, ETs can provide helpful information on catheterization and equipment maintenance procedures.

### **Continent Bladder Replacements**

For men and women who meet special criteria, the T-pouch orthotopic bladder (similar to the Kock pouch), and the neobladder (Studer and variations) are internal pouches that can actually be reconnected to the urethra to provide near-normal urination. Patients may require lengthy rehabilitation and exercise to strengthen and

retrain the muscles and nerves that control the urinary sphincter. The majority find continence is easily maintained during the daytime, but may need to wear a pad as a safety measure.

Nighttime incontinence, however, remains a problem for many, and some never achieve 100% continence. Some people wear Depends, and some get up a few times during the night

to urinate. Some men use a penile sheath (also called condom catheter) with a tube connected to a collection jug. In some cases, hypercontinence (inability to urinate) is an issue and those individuals have to catheterize through their urethras to empty their neobladders. The bladder cancer website, <http://blcwebcafe.org>, has several members with neobladders. Their experiences range from total continence to hypercontinence. They are a knowledgeable and excellent source for information and tips on dealing with neobladders.

### **General Information**

Urostomates need to be aware that any symptoms of kidney infection (chills, fever, flank pain, dehydration, unusual fatigue, change in the volume, color or odor of urinary output, or a change in the amount or color of mucus) require immediate medical attention. An infected kidney is not only excruciatingly painful, but may result in permanently impaired kidney function.

Early oral antibiotic treatment may control a minor kidney infection. Urine cultures and blood tests help determine the specific bacteria involved, so the appropriate antibiotic can be given. If stronger, intravenous antibiotics are needed, this generally means a few days in the hospital as well as a few weeks for recovery. Extensive antibiotic therapy is not the solution to recurrent kidney infections and may result in a resistant strain of bacteria. Recurrent kidney infections warrant further examination, usually an IVP and/or loop-o-gram, or pouch-o-gram, to determine whether or not there is an obstruction or stricture that needs correction.

### **Resources**

Contact United Ostomy Associations of America for an affiliated support group in your area. Call 800-826-0826 or go to [www.ostomy.org](http://www.ostomy.org). To find an ostomy nurse, visit [www.wocn.org](http://www.wocn.org) or call 888-224-9626. 🐾

# Dietary Considerations

## Advice on what to eat and avoid after colostomy and ileostomy surgery

By Sharon Osgood BSN, RN, CWOCN  
and Christina Handschuh, RD

Having an ostomy does not mean that you have to give up the enjoyment of eating. Eating is actually an extremely important part of your recovery process, but food tolerances can vary drastically.

Finding foods that are best for you may require some trial and error, but most people gradually return to their normal diet without even thinking about their ostomy. Depending on the type of ostomy you have and the condition for which it was created, you may have dietary considerations to adopt.

### The Digestive Process

Food starts to break down in the mouth as you taste and chew. Once the food goes down the esophagus and into the stomach, gastric juices and stomach contractions break it down even further. Then, the food is passed into the small intestine. Almost all nutrients are absorbed here. Whatever is not used, or is undigested, passes into your large intestine. Liquid is absorbed into the body through the walls of the colon. The waste becomes more solid as it is propelled toward the rectum where it is stored until it is excreted.

An ostomy interrupts this process. In some cases, this can impact the absorption of nutrients. Generally, the less intestine removed, the less of an impact on nutrient absorption. Also, the farther from the mouth an ostomy is formed, the greater chance of normal absorption. For example, a sigmoid colostomy will have a minimal impact while an ostomy created in the middle section of the small intestine (jejunostomy) could make absorption difficult. An ostomy for the urinary tract will not impact the absorption of nutrients as much as an ileostomy or colostomy. What is important with a urostomy is maintaining kidney function and urine output through adequate fluid intake.

### Returning to Normal

After major abdominal surgery, your bowel needs

rest. Your return to a “normal” diet will begin gradually as you move from fluids to solid foods. Most people have little appetite after surgery. In order to heal, you will need to take in fluids, vitamins, minerals and calories to gain strength.

While there is no special ostomy diet, certain foods can affect the output from a stoma. There are foods that can make you gassy, cause diarrhea or constipate. You need to learn what foods agree with you and which you may want to exclude. It is wise to add just one new food at a time. This way, you can tell which foods may be giving you increased gas or odor or those that just don't agree with you.

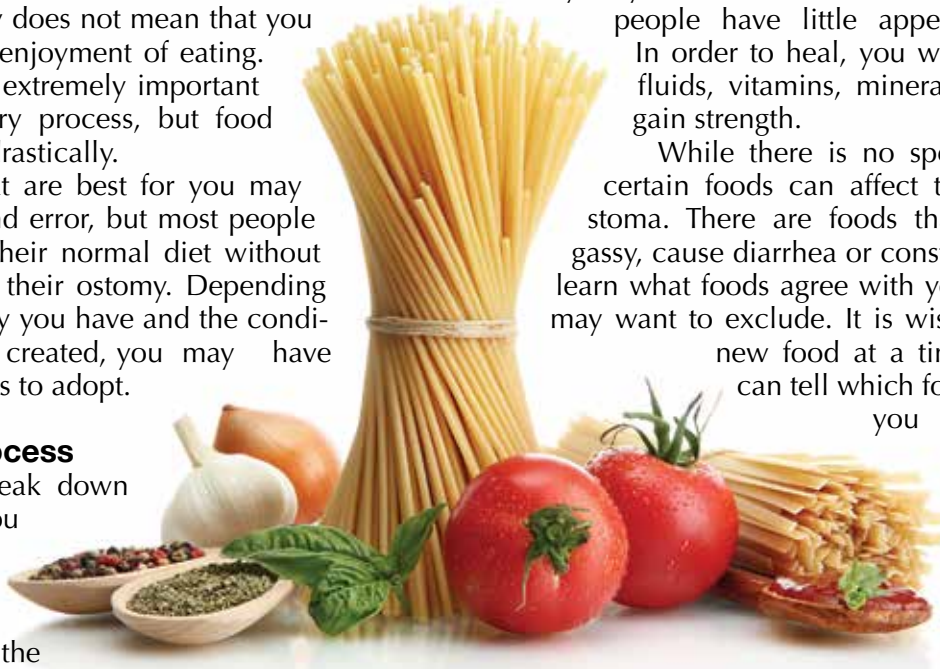
If you have special circumstances or need additional help, it is wise to ask your physi-

cian to recommend a registered dietician. Even if you follow all of the advice from your medical care team, you may experience difficulties with certain foods right after surgery. If this is the case, you should stop eating the foods that bother you.

When you first start eating solid foods, it is especially important to avoid foods that are high in fiber, such as whole grains, dried beans, and most raw vegetables and fruits. Typically, food with less than four grams of fiber per serving is considered low fiber. After two to three weeks, you can add higher fiber foods in small amounts to see if they cause symptoms. As you heal, you can try foods with more fiber, such as whole grain foods. You may find it helpful to write down how certain foods make you feel.

### Flatus and Odor

First of all, it is normal to have gas, but certain foods and eating habits can certainly influence it. Gas is produced when sugars, starches and fibers are broken down in the large intestine. It may take five or six hours from the time you eat until gas passes from your stoma. Gas can also develop from the way you eat, so you



should eat slowly. It will also help to avoid drinking through a straw and talking with food in your mouth.

You can buy products to help reduce gas, like Beano.<sup>®</sup> In addition, pouches with charcoal filters deodorize gas. Sometimes, liquid stool clogs the filter, at which time the pouch can be changed. Foods that cause gas in one person don't necessarily cause gas in everyone, so take note of what foods affect you.

The only time you or anyone else should notice an odor is when you are emptying your pouch. Even then, pouch odor can be reduced with liquid pouch deodorants. Some people prefer to carry bathroom deodorizer with them. If you notice odor at any other time, check your pouching system to see if it is secured properly and/or if there is a leakage problem.

### **Colostomy Guidelines**

Sometimes, you can get constipated just as you may have before your colostomy surgery. To help prevent constipation, eat a diet high in fiber, fruits, vegetables and whole grains. If the constipation does not resolve, check with your physician about considering a laxative.

Diarrhea can be caused by a flu-like illness, medication such as an antibiotics and foods such as dairy products. If you have diarrhea, try lactose-free products. White rice, potatoes and pasta can help thicken stools and can be good choices if you have diarrhea.

When you have diarrhea, your body loses water, sodium and potassium. You'll need to drink plenty of extra fluids, including an eight ounce glass of water each time you empty your pouch. Electrolyte replacement drinks can help you replace sodium and potassium. If you have three or more consecutive loose stools, however, you should contact your doctor.

### **Ileostomy Guidelines**

After surgery, the eating plan may be limited to clear liquids. As you recover, you will start low-fiber foods. Try solid foods one at a time. Stop eating them if they cause any symptoms. You can try them again within two to three weeks. Most patients return to a normal diet within six weeks.

You should also be drinking 8 to 10 glasses of fluids every day unless your doctor tells you otherwise. Since you no longer have a large intestine to absorb water and fluids are lost through your stoma, you need to help your body hydrate. However, sugary beverages such as fruit juice and soda should be limited because they

may lead to dehydration. If care is being provided to a senior citizen, be mindful of intentional fluid restriction because of fear of incontinence or choking (dysphagia).

You may be dehydrated if you notice your mouth or tongue is dry; urinate less often; notice your urine is darker than normal; get dizzy when you stand; feel weak and don't react normally; have cramps in your legs or abdomen; are unable to think clearly; or feel tingling in your hands and feet.

Call your doctor if you show signs of dehydration or have three or more consecutive loose stools. If you notice the symptoms of extreme dehydration – confusion, dizziness and shriveled skin – go to the emergency room. If you are not seriously dehydrated, you will need to replace electrolytes by drinking or eating broths, bouillon, electrolyte or sports drinks, rice water, orange juice, pretzels, crackers, canned soup, bananas or potatoes.

With an ileostomy, you may still get diarrhea or watery stools from time to time. Since your pouch may fill more quickly than normal, you will need to empty it more often. Diarrhea causes you to lose water, sodium and potassium, all of which your body needs. Foods that thicken output include pudding, creamy peanut butter, potatoes, bread, pasta, applesauce, cheese and rice.

### **Avoiding Blockages**

Those with an ileostomy are at an increased risk for food blockages. They are less common with colostomies. Before your ileostomy surgery, large particles of food passed through your large bowel. Now, however, large food particles can easily get caught where your intestine comes through the abdominal wall. If this happens, it can cause a blockage. A food blockage can cause abdominal cramps, pain and watery stools with a bad odor. Stool may be released in spurts as your intestines try to get the waste past the blockage.

For the first six to eight weeks after surgery, avoid high-fiber foods that absorb water such as oats, citrus fruits, apples and beans. Even long after your surgery, certain foods may still cause you to have a blockage. If you suspect that a food has caused a blockage, avoid that food for a while. Adding these foods back into your diet one at a time, and in small amounts, will help you know if the food bothers you. Foods that may cause a food blockage include nuts, popcorn, coconut, dried fruits, celery, mushrooms, foods that have fibrous peels and raw and crunchy vegetables (carrots, broccoli, cauliflower and Chinese vegetables).

***“Having an ostomy does not mean that you have to give up the enjoyment of eating. Eating is actually an extremely important part of your recovery process, but food tolerances can vary drastically.”***

You can also help avoid a food blockage by eating slowly, chewing your food thoroughly and drinking fluids with your meals. If you have a food blockage and are not vomiting with some output from your stoma, try to increase your fluid intake slowly. Drink hot tea, or take a hot shower and run water on your back to relax your abdominal muscles. If you have no output from your stoma and you are vomiting, do not drink any liquids. Contact your doctor immediately.

## Medications

Before your ileostomy surgery, you may have been taking medications that are absorbed gradually through both your small and large bowels. Now that you do not have a large bowel, these medications can only be partially absorbed or not absorbed at all. This can happen with certain coated pills (called enteric-coated pills) and time-release capsules.

You should always tell your pharmacist that you have an ileostomy. Knowing this, your pharmacist can make sure you get the right form of your medication, both prescription and over-the-counter. If you ever notice pills in your stool or pouch, be sure to let your doctor and pharmacist know. Never crush your medications or open time-release capsules. Always avoid laxatives. They can cause severe dehydration.

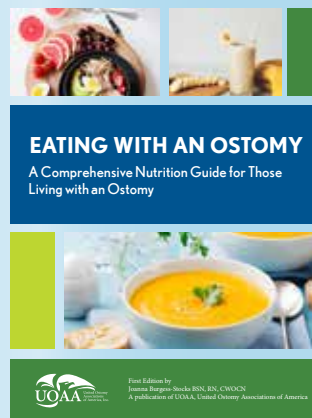
Vitamin B12 is present in meat and other foods, but due to the nature of your surgery, you may have difficulty absorbing this vitamin. This may result in anemia. Anemia is a condition in which you do not have enough red blood cells and it causes unusual tiredness among other symptoms. If you have any concerns, speak with your doctor about whether a Vitamin B12 supplement is right for you.

## Urostomy Dietary Guidelines

You generally should not have to change your diet after your urostomy surgery. However, if your doctor has recommended a special diet, you should follow that advice. Because of the nature of your surgery, your anatomy no longer has the natural defense to help prevent urinary tract infections (UTIs). Drinking adequate amounts of fluid will help to flush your urinary tract of bacteria and help prevent UTIs. Unless your

# UOAA Guide

UOAA and Joanna Burgess-Stocks, BSN, RN, CWOCN have produced a comprehensive nutrition guide for those living with an ostomy. To view and download, go to [www.ostomy.org/diet-nutrition](http://www.ostomy.org/diet-nutrition).



doctor says otherwise, drink 8 to 10 glasses of fluid every day. You might notice some mucus “shreds” in your pouch, which is normal. Drinking more fluids will help to minimize mucus shreds. If your urine is dark, you may be dehydrated, so you should increase your fluid intake.

It's best to drink mostly water or fruit juice. In moderation, tea and coffee are fine, but be aware that

any caffeinated drink may cause dehydration. Pure cranberry juice or cranberry pills are good because they can help increase the acidity in your urine which may prevent UTIs. If you are on blood-thinning medication, always check with your nurse or doctor before adding cranberry juice to your diet.

Signs and symptoms of a urinary tract infection: increased mucus in urine; cloudy and strong-smelling urine; fever; confusion; loss of appetite; back pain; nausea; vomiting; blood in urine.

If you experience any of these symptoms, contact your doctor. You may want to ask your doctor if you can take Vitamin C to increase the acidity of your urine. Keeping your urine acidic may help to prevent UTIs, decrease urine odor and keep your skin healthy.

## General Guidelines

The latest research suggests that the body can adjust to minor and major resections of the bowel without increasing the risk for undesirable health conditions. However, there are several strategies to encourage adequate nutritional intake and prevent conditions that may require medical intervention.

Monitor any changes in appetite as well as symptoms of dehydration. Keep a record of your weight. Rapid transit of food (diarrhea) through your GI tract can be dangerous. If sudden changes occur that are not normal for you, contact your doctor immediately.

Feeling comfortable with your body is important, especially after this type of surgery. It's equally important to enjoy good food as a part of a full life. We're hoping these guidelines are helpful to you. If you have any questions regarding stoma care, product usage and availability please contact your doctor or ostomy nurse. These guidelines are for general use and information. You should always consult with your health care provider first. ☂





# Donations are Critical to Supporting the Ostomy Community

[www.ostomy.org/donate/](http://www.ostomy.org/donate/)

## Choose Where Your Donation Goes

### Advocacy Fund

Donations to this fund allow UOAA to advocate on every front for the issues our constituents care about most and help empower people to expect more from their healthcare.

### General Fund

Giving helps UOAA to create trusted resources, connect people to support groups for assistance, maintain our educational website and offset organizational expenses.

### Ostomy Awareness Fund

Your dollars help get our New Ostomy Patient Guide to those who need it the most and to spread ostomy awareness to new sectors of the medical field and society at large. Your donation also supports annual events such as Ostomy Awareness Day.

### Memorial/Tribute

Your tax-deductible tribute gift will honor or remember a loved one, and immediately support the mission of UOAA.

## Become a Member of The Phoenix Society!

*The Phoenix Society* recognizes those who are able to sustain and/or increase their total annual donations of \$500 or more each calendar year\* to UOAA. As you consider your charitable gift planning, we encourage you to continue to give what you can, and if possible, increase your financial support.

There are four levels of *The Phoenix Society*:

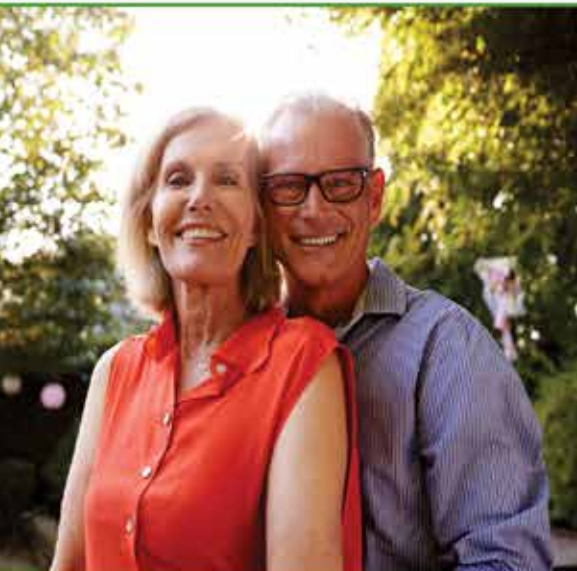
**Sapphire Level**

**Emerald Level**

**Ruby Level**

**Diamond Level**

*\*Your member benefits will be recognized in the following calendar year in which your donations were made.*



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## For More Information:

Visit our website at [www.ostomy.org](http://www.ostomy.org), email us at [info@ostomy.org](mailto:info@ostomy.org) or contact our information line at 800-826-0826.

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# Swim Confidently

From public pools to open ocean to hot tubs, go ahead and jump in

By Ed Pfueller,  
UOAA Communications  
Manager

After healing from ostomy surgery, people of all ages enjoy swimming, surfing scuba diving or just relaxing in a hot tub. We understand the anxiety from worrying about leaks can keep some people out of the pool. There are no ostomy specific restrictions to swimming in public places. "Swimming has made me stronger both physically and emotionally. It is a great outlet and has made me even healthier. I feel and look more beautiful," says Lynn Wolfson of Florida. Lynn has two ostomies and swims in triathlons. Here are some solutions to common concerns.



*I'm afraid that my pouch will leak or my wafer will loosen while I'm in the water.*

Remember, your pouching system is resistant to water and with a proper fit, it is designed not to leak. If you have output concerns, eat a few hours before swimming. A good habit is to empty your pouch before taking a dip. If you are hesitant about how your wafer will hold, take a practice soak in your bathtub. It is best to avoid applying a new skin barrier/wafer or pouch right before swimming. The WOCN Society recommends allowing 12 hours for proper adhesion. Using waterproof tape or water-specific barrier strips are not necessary for most, but can provide peace of mind. There are a wide variety of ostomy supplies on the market for swimming and you should be able to find a solution that works best for you. If your pouch has a vent, use the provided sticker over the air hole so that the filter remains effective.

*What can I wear or do to help conceal my pouch and keep it secure?*

Wearing a patterned or darker color is less transparent than a light-colored swim garment. Options for women include patterned and boyleg one-piece suits.

For a two-piece suit, consider a mix and match of tankini tops, highwaisted bottoms or boy shorts. You can also look for a suit with a concealing ruffle or skirt. Men often favor a higher cut waist for trunks, or suits with longer legs. Stretch fabric undergarments and swim or surf shirts also provide support. Ostomy bands and wraps are also commonly used.

On the beach or poolside don't be surprised to know that some ostomates are comfortable with simply wearing the swimsuit of their choice- with swim fabric pouch covers or just an opaque pouch. There is also swimwear and accessories specifically made for ostomates.

*What do I do if I am approached by pool personnel concerned that my ostomy is an open wound or believe ostomy pouches are not allowed in pools?*

The best approach is to stay calm and try to educate. However, unless you or another person tell pool personnel, no one should know you have an ostomy. Contact UOAA at [info@ostomy.org](mailto:info@ostomy.org) if this is a recurring issue. You can also visit [www.ostomy.org/swimming-pool-discrimination/](http://www.ostomy.org/swimming-pool-discrimination/) for additional resources. The Americans with Disabilities Act ensures your right to pool access and most disagreements can be solved through education before exploring any legal recourse.

Some scuba diving operations also incorrectly list having an ostomy as an exclusion on pre-dive paperwork. Contacting PADI (800) 729-7234 can help educate them that there is no reason to avoid diving if you have an ostomy pouch. Meet with a WOC nurse for questions about what supplies may work best for you and stop by your local UOAA Affiliated Support Group or visit our discussion board at [ostomy.org](http://ostomy.org) to ask what your peers do to feel confident and secure while swimming. 🏊

# Travel Tips

## Great advice to hit the road, airways or sea with an ostomy

By United Ostomy Associations of America

In these days where extra precautions for security are being taken worldwide, it would be wise for traveling ostomates to do advance planning in order to avoid possible problems. Some suggestions are:

- Pre-cut all pouches at home, as you may wish to avoid having scissors in your carry-on luggage (see additional comments below).
- Know your stoma size in both metric and inches if you will be traveling in Europe or Asia.
- Pack supplies in carry-on and checked luggage.
- Take extra supplies in case you are stranded.
- Ostomates who have concerns about airport screening should contact TSA Cares at least 72 hours

before travel: 855-787-2227 or email TSA-Contact-Center@tsa.dhs.gov. They will coordinate assistance available from a Passenger Support Specialist (PSS) and/or customer service manager at the airport.

- Download a travel notification card from [www.ostomy.org](http://www.ostomy.org). This is NOT a special security pass but it is a way to communicate discreetly to agents that you have an ostomy. You can also show a note from your physician explaining any of your medical conditions.
- Understand security. Expect to be screened without having to empty or expose the ostomy through the advanced imaging technology, metal detector or a pat-down. You may be required to conduct a self pat-down of the ostomy pouch outside of your clothing, followed by a test of your hands for any trace of explosives. If an incident occurs outside of protocol, report it to the TSA and follow-up with UOAA.

For domestic flights within the United States, you are free to carry scissors in your carry-on as long as the cutting edge is no longer than four inches. If you travel outside the U.S., you may face more severe restrictions on carrying scissors. For flights departing Canadian airports, you can carry scissors in your carry-on, but the blades must not exceed 6 cm (2.4 inches). ✂

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# Intimacy with an Ostomy

Your love life doesn't end after surgery – it may actually improve

By Laura Herbe BSN, RN, CWOCN

'So now I have a stoma. I look different, I go to the bathroom different, and I feel different. Will I still be attractive?'

It is normal to have concerns about your quality of life following ostomy surgery. High on this list of concerns may be questions about sex, intimacy and will it be possible to enjoy a fulfilling sex-life after your operation.

Many factors and concerns can impact sexual function following ostomy surgery. The type of disease, reasons for the operation, surgical procedure and recovery all play an important part in sexual function and fulfillment, but equally important is personal adjustment, acceptance, support and discovering what aspects of sex and intimacy are most important to you and your partner. Your sexuality cannot be taken away from you. It is a part of your being and intimacy and sex are a natural part of life.

Can I still have a satisfying sex life after ostomy surgery? Yes, but it is critical to pay attention to ALL aspects of your well-being in relation to your sexuality.

## Adjusting after surgery

Even the most prepared person can feel overwhelmed and have difficulty adjusting to a stoma. You need to take the time to heal, both physically and emotionally. The usual discomfort, exhaustion and fatigue and sometimes even depression after surgery can all have a direct effect on desire and libido. Doubt and anxiety also prevent you from focusing on your partner. So before resuming sexual activity it's important to have a healthy perspective physically, psychologically and emotionally. Accepting yourself, feeling comfortable and confident with the way you, your stoma and pouch

look not only helps you to feel better, but it also makes it easier for your partner to get comfortable and accept the changes as well. Together, the two of you can rediscover intimacy that you enjoyed before.

## Getting comfortable

Once you are both feeling more comfortable with



the changes to your body, think about how you can approach sexual activity in a relaxed, non-pressured way. Open, honest communication is key, even if talking about this topic is uncomfortable or even embarrassing for you. It might be helpful when starting this conversation to begin by reminding each other how much you still love each other. This can definitely help relieve some of the doubt and anxiety you both may be feeling. Share your fears of potential rejection. And don't let your partner misinterpret your own fears as an initial reluctance to have intercourse. You also need to listen well to his or her concerns. Maybe they are afraid they will hurt you or your stoma during intercourse. Honesty in talking about this topic will only help build mutual trust and respect between the two of you. Be patient and

allow both yourself and your partner the time you need.

Don't underestimate the power of intimacy without intercourse. Make time for holding each other, talking, kissing and cuddling. These are all important for a healthy, active sex life and a fun way to get both of you comfortable and ready for intimacy.

### **Sexual positions**

Intercourse will not injure your stoma and most positions will not disturb the pouch. Close body contact and sexual movement will not injure the stoma either. For some, choosing a position that keeps the weight off the stoma is most comfortable.

Some options include side-lying, front to back or putting a pillow under your abdomen to support hips and stoma. Placing a pillow under the hips for missionary position also helps support the pelvis or 'woman on top' works well too. If you are in a wheelchair, be sure to lock the brakes to prevent movement and support the back of the chair against the wall.

You should never have intercourse through the stoma nor should you have anal intercourse if you have a pelvic pouch (IPAA, J-pouch, S-pouch). If a woman has had vaginal reconstruction or recto-vaginal fistula, she will need her doctor's OK to resume vaginal intercourse. Talk with your doctor or Wound, Ostomy, Continence (WOC) nurse about any types of sexual activity that you should avoid.

### **Mind that pouch**

How someone looks, feels and smells all have the ability to heighten sexual pleasure. Keeping the pouch clean and empty is a good idea and make sure your pouch has an odor-proof secure seal. It also helps to avoid gassy foods like cabbage, onions, eggs and spices prior to sex. If the mood is spontaneous, make sure to empty your pouch in advance, otherwise, you may want to put a new pouch on beforehand.

There are several good options if you'd like to use a smaller pouch. Some people switch to a stoma cap. Other people may switch to a smaller mini-pouch or a closed-end pouch. All of these choices are smaller, less bulky and more discreet and are often referred to as a "passion pouch." Switching to one of these smaller pouches, as well as keeping your pouch clean and deodorized, should allow you to be worry-free. Make sure that you return to your regular-sized pouch afterwards.

### **Feel and look sexy**

Intimate apparel not only helps you feel more confident and sexy, but it can also decrease the annoying pouch swing-motion that occurs during body movement.

There are a variety of intimate apparel options to help conceal a pouch. Women might want to consider teddies, camisoles, wraps or silky robes, and panties with pouch pockets or peek-a-boo thongs.

Men might want to consider tank tops, a cummerbund-type garment or boxers with a waistline that helps secure the pouch. Another product is an array of colorful pouch covers, which can allow you to feel more discreet.

### **Potential concerns**

Sometimes ostomy surgery involves removing the rectum. In men, the nerves that regulate erection and ejaculation are close to the rectum. Some men will have problems with erection and ejaculate into the bladder (retrograde ejaculation). However, the ability to achieve orgasm is not affected. Erectile dysfunction may be temporary for up to one year. If problems persist, medications or surgical implants may help.

Many women experience vaginal dryness. There are many lubricants available or you can ask your doctor about hormone cream or vaginal suppositories and rings. For some women, surgery might involve removing the rectum and part of the vagina which can cause the vagina to feel too small or tight. This can cause pain during intercourse. Different sexual positions may be a solution as well as the use of vaginal lubricants.

If you're unable to resume having intercourse, or if you're unable to find the same level of enjoyment as before, talk to others. Your doctor and WOC nurse are an excellent source of information.

### **Going for it**

It takes time, patience and a good support network in the short and long term to navigate sexual intimacy with an ostomy. In addition to talking to your doctor or WOC nurse ([www.wocn.org](http://www.wocn.org)), there may be support groups in your area. Couples can consider attending a group through United Ostomy Associations of America ([www.ostomy.org](http://www.ostomy.org)).

You'll find that it can be very helpful to get suggestions for both you and your partner from others who have faced and overcome the same challenges. Or you and your partner might want to talk with a therapist or counselor. A counselor is a good resource to help with both body image and intimacy issues.

Resuming or developing an intimate relationship is a good sign that you've resumed living a full life after your surgery. Remember, an ostomy is a change to your body only. You are still the same person. And there is no reason why your intimate relationship with your partner should change. After all, the most important sexual organ is the brain. 🍷

# Back to Work with an Ostomy

## An ostomate's guide to getting back on the job

By UOAA's Advocacy Manager, Jeanine Gleba and Communications Manager, Ed Pfueller

From the board room to construction sites to long shifts in a hospital, people living with an ostomy (colostomy, ileostomy, urostomy, etc.) are able to work every job imaginable. Embracing a new normal in life after ostomy surgery is key to living an active life. For many, that daily norm means returning to work.

According to the American College of Surgeons once you have recovered from surgery, your ostomy should not limit your return to work.

The timing of your return depends on your individual recovery and the physical demands of your job.

Whether to tell your employer or co-workers is a personal choice depending on your work situation, but some feel it helps to inform others if you require frequent breaks or other accommodations. Remember that your co-workers will likely not realize you have an ostomy unless you tell them.

Here are a few tips from UOAA's Facebook community and Advocacy Network.

**Be Prepared:** In the case of a possible leak, have a complete change of your ostomy supplies as well as a change of clothes you can bring to the restroom. "Pack in a backpack, zippered tote, or small duffle bag that you can store in your desk drawer or locker." –Jane Ashley-publishing/author

**Know Your Rights:** You have legal rights under the American with Disabilities Act and the U.S. Rehabilitation Act of 1973, which prohibits employment-based discrimination. Workplace complaints to the UOAA are rare but they still occur. Read our self-advocacy resource here. "My coworkers all knew, especially of the trials and tribulations pre-op. But still, there was hostility and harassment at times." Jacqu- Retired Government.

**Dispose/Empty Your Pouch Properly:** Investigate the



best restroom/changing facilities to empty or change your pouch. Consider the use of pouch or ostomy deodorizer drops or spray, and plastic bags for disposal. "My purse contains a 1-ounce bottle of Poo-Pourri, a Tide pen, a lubricating deodorant sachet, and baby wipes." Margie -Academia.

**Find the Best Clothing for Your Job:** Consider loose clothing if sitting for long hours, or try a stoma belt if you have an active job. A skin barrier may be helpful if you perspire on the job. "I wear a hernia belt," Megan-Nursing.

**Don't Stress Stoma Noise:** If your stoma decides to speak up at the next meeting, relax. You may be the only one who notices. "All bodies make sounds," Penny- Construction.

**Hydrate:** "Stay on top of your fluid intake. Don't get distracted and have it result in an ER visit," Heather Brigstock-Nursing.

**Find Support:** Know that you are not alone. UOAA has more than 300 affiliated support groups that offer advice, information and support.

With some preparation and patience you'll soon be confident in the workplace, and for many, feeling in better health than before surgery. 🍀



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