



### MEETING INFO:

Meetings are held the first Tuesday of each month (except July and August) at 7:30 PM in the **Rex Surgical Center Waiting Room, 4420 Lake Boone Trail, Raleigh, NC**. Enter through the Rex Hospital Main Entrance, which is near the Parking Garage.

### REMINDER:

In the event of inclement weather on the day of a scheduled meeting, please contact Rex Healthcare at 919-784-3100



### CALENDAR OF EVENTS:

March 7: Triangle Ostomy Assc. meeting, 7:30 Rex Hospital  
March 17: St. Patrick's Day  
March 20: Crohns and Colitis meeting, 7:30 Rex Hospital  
April 1: April Fools Day

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## MINUTES OF THE February 7, 2006 MEETING OF THE TRIANGLE OSTOMY ASSOCIATION

Jennifer Higdon, Vice President opened the meeting for Discussion at 7:30 pm. Jennifer announced that Dan Wiley, President was unable to attend the meeting due to illness. The J-pouchers provided wonderful refreshments!

Our group name has officially changed to "The Triangle Ostomy Association" as noted in the most recent newsletter. Jennifer stated that Dan is in the process of completing paperwork for our group to join the UOAA organization. The UOAA is an "organization of organizations" that serves as a national Political Action Group by lobbying on behalf of ostomates. There are no individual dues, so if members wish to receive the UOAA magazine, they will need to contact the UOAA directly for a subscription. The UOAA has agreed to allow us to copy articles from their magazine and re-print them in our newsletter.

The focus of this meeting was to provide a setting where members could ask questions and share ideas regarding their ostomies. Jennifer facilitated the meeting by asking questions and encouraging others to share information amongst the members in attendance. The following is a summary of the questions, answers and information shared during this meeting:

How many days wear time do you have with your ostomy pouch? The wear time amongst members varied from 4-7 days. One member stated that she writes the date and time of when she changes her bag onto the bag itself so she can better evaluate her average wear time. Members agreed that this was an excellent idea. Some members stated that they know it is time to change their bag by the degree of wafer deterioration and by the itching of the skin around the stoma

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One remedy to skin irritation at the stoma site was to change the type of base you are using. A member reported that the Convatec pre-cut wafers (2 piece system) have a tape adhesive around the edge that was irritating his skin. He switched to using a non-pre-cut wafer with a thicker adhesive putty that ran all the way to the edge of the wafer, thus avoiding the tape. The skin condition is improving.

One member stated that she has to empty her colostomy bag 3 times a day which causes a residue buildup of stool around the wafer. She uses Pam spray in her bag and although this is helpful in moving the stool to the bottom of the bag, it does not fully alleviate this problem. Other members acknowledged similar problems that they remedy by using a “squirt” bottle of water to clear away the stool buildup around the wafer/stoma. This is especially helpful if done in the morning after waking up. Lying in a reclined position at night is more likely to cause stool buildup around the stoma/wafer as the colostomy bag is not hanging in a vertical position as it does during the day. Small, plastic, empty soda bottles were also suggested as great tools for rinsing out bags as they are always available when traveling and they have a small neck/mouth for pouring water easily into the opening of the ostomy bag.

One member stated that he has had difficulty with the tape around the wafer not sticking to a concave area over his surgical site. The suggestion was made that as long as the adhesive part of the wafer is making good contact with the skin, the tape can be cut and manipulated not to lie on the surgical scar. If the wafer adhesive putty is not sealing, then additional putty products are available from the ostomy companies to fill in the concave areas around the stoma to maintain a reliable seal.

Another member stated that he has begun using the disposable liners from Convatec. These are available for the 2-piece system. The liner fits into the ostomy bag and is held in place where the 2-piece snaps together. When the liner is full, the ostomate removes the bag and discards it. The bags are flushable. They come in box of 300 and the member believes the price is around 25 cents each. They are thin, but very durable. Vendors will send a dozen to anyone that calls and asks for samples.

The question was asked if members with colostomies take laxatives? Most individuals with colostomies have normal bowel movements as they did prior to their surgery. So for most of them, laxatives are not needed any more often than a person without an ostomy. Most importantly, laxatives should not be used by individuals with ileostomies as they tend to have liquidly stools, frequent bowel movements and can become easily dehydrated. However, intestinal blockages can occur with both colostomies and ileostomies. These episodes are usually triggered by eating too much of a certain food (often high fiber foods such as certain fruits/veggies, nuts) and NOT drinking enough water/liquids. Different foods effect people in different ways. It is recommended that individuals try high fiber foods in small amounts and drink a lot of fluids until they are able to identify what foods affect their gastrointestinal tract.

Hernias were also discussed. Several members have hernias near their stomas. The general consensus among physicians is, if it isn't causing pain, discomfort or interfering with the wearing of the ostomy bag, then leave it alone. Surgery can be difficult and often results in muscle weakness around the area of the hernia. This can cause additional hernias in the future. Many individuals use a binder to offer support to the herniated area. However, for some individuals, the binder does not stay in place or can press uncomfortably on the stoma, causing them to discontinue the use of the binder. When a hernia is suspected, it is a good idea to discuss your concerns with your physician who can better evaluate what is appropriate for your individual situation.

# Osto-EZ-Vent

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### SUPPORT GROUP

- Date: Third Monday of every month
- Time: 7:30 pm – 9:00 pm
- Place: Rex Healthcare,  
surgical waiting room
- Contact: Laura Bradford 919-233-0163

## TIPS OF THE MONTH

*from [www.sgvmedical.com](http://www.sgvmedical.com)*



- Leakage problems and "bad" skin burns can occur from applying cement too thickly or from not allowing it to dry properly.
- If your stoma gurgles a lot, try eating solid food first at meal time and beverages after.
- Urostomates should avoid carbonated beverages. These tend to make urine alkaline. Stick with cranberry juice and plenty of water.

## RECOGNIZING A STROKE -- THIS COULD SAVE A LIFE!

*From Great Plains Ostomy News*



During a BBQ a friend stumbled and took a little fall – she assured everyone that she was fine (they offered to call paramedics) and she had just tripped over a brick because of her new shoes.

They got her cleaned up and got her a new plate of food – while she appeared a bit shaken up; Ingrid went about enjoying herself the rest of the evening. Ingrid's husband called later telling everyone that his wife had been taken to the hospital – (at 6 pm, Ingrid passed away.)

She had suffered a stroke at the BBQ – had they known how to identify the signs of a stroke perhaps Ingrid would be with us today.

It only takes a minute to read this: A neurologist says that if he can get to a stroke victim within 3 hours he can totally reverse the effect of a stroke...totally. He said the trick was getting a stroke recognized, diagnosed and getting to the patient within 3 hours which is tough. Thank God for the sense to remember the “3” steps.

Sometimes symptoms of a stroke are difficult to identify. Unfortunately, the lack of awareness spells disaster. The stroke victim may suffer brain damage when people nearby fail to recognize the symptoms of a stroke.

### **Now doctors say a bystander can recognize a stroke by asking 3 simple questions:**

1. Ask the individual to **SMILE**.
2. Ask him or her to **RAISE BOTH ARMS**.
3. Ask the person to **SPEAK A SIMPLE SENTENCE**. (Coherently – for example, it is sunny out today.)

If he or she has trouble with any of these tasks, call 9-1-1 immediately and describe the symptoms to the dispatcher.

After discovering that a group of non-medical volunteers could identify facial weakness, arm weakness and speech problems, researchers urged the general public to learn the 3 questions. They presented their conclusions at the American Stroke Association's annual meeting. Widespread use of this test could result in prompt diagnosis and treatment of the stroke and prevent brain damage.

A cardiologist says if everyone who gets this email sends it to 10 people, you can bet that at least one life will be saved.

**BE A FRIEND AND SHARE THIS ARTICLE WITH AS MANY FRIENDS AS POSSIBLE,** you could save their lives or the lives of a loved one.

## HELPFUL WEBSITES FROM DAN WILEY

I recently ran across some websites that I want to share with you. They are from the Mayo Clinic, the University of Pittsburgh and a patient educational site. They are as follows:

1. "Ostomy: Adapting to life after colostomy, ileostomy or urostomy."

<http://www.mayoclinic.com/health/ostomy/SA00072>

2. "Ostomy Nutrition Guide"

<http://www.patienteducation.upmc.com/Pdf/OstomyNutrition.pdf>

3. "Colostomy, Ileostomy, Rectal Pouch Diets"

<http://www.gicare.com/pated/edtgs13.htm>

I think you will find these sites educational and informative so please check them out.

### **Crohn's Disease and the Pelvic Pouch**

*By Yehuda Kariv, M.D., and Feza H. Remzi, M.D. (Cleveland Clinic Pouch O'Gram)*

The pelvic pouch has become the procedure of choice for most patients with ulcerative colitis (UC) who require surgery. The pouch avoids the need for a permanent stoma by preserving the normal route of defecation.

In contrast to UC, Crohn's disease (CD) can involve the small bowel and other parts of the gastrointestinal tract. It has a significant tendency for disease recurrence after surgery. Therefore, in patients with CD, the creation of a pelvic pouch has traditionally been considered inadvisable.

In pelvic pouch patients, CD is associated with higher rates of long-term complications. CD may manifest as an inflammatory process within the pouch, chronic fistulae, strictures and symptomatic small bowel disease proximal to the pouch. Severe recurrence of CD in the ileal pouch might require its removal.

#### **Differentiation**

Despite several classification systems and good clinical, endoscopic, radiological and histological tools, identifying the difference between CD and UC still is sometimes difficult.

In at least 10 percent of colitis patients, no differentiation can be made between UC and CD. Those patients are defined as having indeterminate colitis. In most CD patients who have undergone pelvic pouch procedures, the presumed diagnosis prior to surgery was ulcerative or indeterminate colitis, but those patients subsequently have been found to have CD.

Although controversial, there is limited data that suggests a pelvic pouch operation may be performed in very carefully selected patients with an established diagnosis of Crohn's colitis before surgery. This is supported by several reports that have described an acceptable outcome of a pelvic pouch operation in CD patients free of small bowel and perineal disease before surgery.

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A study done by the Cleveland Clinic Department of Colorectal Surgery on a small group of patients who had their diagnosis revised to CD after pouch surgery has demonstrated a CD recurrence rate of 35 percent, and overall pouch loss (the need for permanent stoma or pouch resection) in 12 percent of patients at four years postoperatively.

Most other studies on patients with an initial or final diagnosis of CD, however, have shown higher rates of CD recurrence and loss of the pouch (range: 10 percent to 56 percent). CD recurrence in the pouch is sometimes difficult to differentially diagnose. Features to support a diagnosis of CD of the pouch are granulomatous inflammation on histology, pre-pouch ileitis or chronic fistulae.

## **Therapeutic Options**

In patients who develop CD of the pouch, medical therapeutic options are available to attempt pouch salvage. The combined strategies of anti-CD medications, anti-inflammatory drugs, antibiotics, immunosuppressives, and probiotics are used with variable success rates.

In addition, there is increasing experience with Infliximab (Remicade) to treat CD of the pouch. Infliximab, an antibody against the inflammatory mediator tumor necrosis factor (TNF), is known to be beneficial in treatment of CD-related complications. It has been recently suggested to be beneficial in the treatment of patients with a pelvic pouch who develop CD-related symptoms resistant to conventional medical therapies.

Sometimes surgical interventions are required to treat complications like abscesses, fistulae, strictures and bowel obstruction. These might cure CD-related complications or provide symptomatic relief and do not necessarily signal a failing pouch. A redo operation, where the pouch is revised by either repair or removal and creation of a new pouch, is also a possibility that might be considered for selected patients.

Sometimes, despite all efforts, the pouch fails. Then a permanent stoma with or without removal of the pouch is required. Carefully selected patients might be offered the creation of a continent ileostomy (K-Pouch) that may eliminate the need for an external appliance and potentially improve quality of life, but this may be associated with a considerably high rate of complications.

## **Keeping the Pouch with Crohn's**

Although the rates of pouch failure and complications in CD patients who undergo pouch surgery are higher compared to UC, the majority are expected to keep their pouch with good functional outcome.

Medical and surgical treatments are available to assist in reaching this goal. Such results may be improved by the continued development of medical strategies for the long-term suppression of CD. Until then, pouch surgery cannot routinely be offered to patients with a known diagnosis of Crohn's proctocolitis. However, in very carefully selected cases, prospective evaluation of this procedure should continue.











