

The Mailbag

The Ostomy Support Newsletter Of Jacksonville, Florida

Support group meets the 3rd Sunday of each month 3 p.m. 4836 Victor Street

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Next chapter meeting will take place on
Sunday Sunday April 15th
Come join us!
3PM 4836 Victor Street
Speaker TBA



Jacksonville Chapter is a member of the United Ostomy Association of America.
Please take the time and visit their Website <http://www.ostomy.org>.

Public TV Documentary Movie

UOAA entered into a contract for the publication of a five-minute ostomy public awareness movie that will appear on public TV; the National Medical Report as shown on cable; network and international TV as part of Voice of America.

This excellently produced project—coordinated by UOAA President Elect Kristin Knipp—can now be viewed on the UOAA Internet site at www.uoaa.org/uoaa_psa.shtml. One may also view the movie at <http://uoaa.wordpress.com/>.

We encourage you to send one of these links to anyone with an interest in ostomy surgery; i.e., our members, local medical professionals, family and even friends who you might want to have better understanding about our organization.

Know About Blockage

By Henly C. Finch, MD

The small and large intestines are as different in function as are the arm and leg. The primary function of the small intestine is to take nutrition from digested foods; the function of the large intestine is to absorb water out of the food residue. Consequently, there is a difference in the discharge from an ileostomy, a colostomy or a rectum. The discharge from the small intestine, which functions on liquid material and moves contents forward quickly, is liquid and soft.

In the large intestine, the contents are changed from liquid to solid—through the process of absorbing water. The movement is much less rapid, and the discharge is solid or even hard.

Movement of the food mass through the small intestine is never more than a few hours. Movement through the large intestine frequently takes from 36 to 84 hours. Thus, when anything blocks the forward motion of the stream of the small intestine, an immediate chain-of-events is set up.

There is pain, then gripping and cramping. Later, if there is no forward motion, a backward motion of fluid occurs, involving vomiting. The most frequent cause of the onset of this chain-of-events is blockage at the ileostomy stoma.

Usually, this is precipitated by undigested food; i.e., a bean, pea, peanut, popcorn, corn kernel, pulpy-type foods, meat casings, stringy vegetables, shrimp, lobster, coconut, raw vegetables or something similar to these.

The best way to handle a blockage is not to allow it to occur in the first place. This is done primarily by chewing foods well. However, if symptoms of blockage occur, notify your doctor and follow his/her advice. As blockages may arise from other causes than undigested food particles, observe the following two cautions:

- Do not take any kind of laxative without your doctor's specific order. Any laxative may cause additional complications and pain.

- Do not take any medication for pain without your doctor's specific order. Pain medication may mask a symptom that the doctor needs to know about.

People with urostomies must be sure to take particular precautions in order to prevent blockage. Where the ileum or colon is rejoined after a segment is removed for the conduit, a stricture could occur, which is not as extendible as the normal intestines.

Keep some white grape juice and mineral oil around your home . . . just in case. Some symptoms of a blockage can be relieved with a glass of white grape juice or a tablespoon of mineral oil. In addition, it can work wonders sometimes, even to the extent of loosening the blockage enough to pass.

Frequently Asked Questions

By Secure Start, Hollister Incorporated

Q How do I know if my stoma is healthy?

A Each person's stoma is unique. The stoma is always red and moist, much like the mucus membrane in our mouths. A stoma is not painful, as there are no feeling nerve endings in it. Minor, temporary bleeding of the stoma is normal, if it is rubbed or hit.

Q How often should I change my pouching system?

A You should expect predictable, sustained wear time from your pouching system. This is related to the type of skin barrier used, the shape of the barrier—convex or flat—and a number of other factors; i.e., climate and your activity level.

Some people prefer to change their pouches daily, while others wear their pouching systems for up to seven days. If you have trouble having your skin barrier to stay in place, you may need to get help with fitting and product selection. The best source of help is a certified wound, ostomy, continence nurse—a CWOCN.

Q What is the skin barrier?

A The skin barrier is the waxy like part of your pouching system that sticks to your skin. Modern, disposable skin barriers are primarily responsible for holding your pouch securely and

comfortably to your body. Tape may be used as an additional support for people who are particularly active, but if the skin barrier does not hold the pouch onto the body, tape alone will not be sufficient.

Q Is that the only purpose of the skin barrier?

A Holding your pouch on is a pretty important, but the skin barriers main purpose is to protect your peristomal skin. Without the skin barrier, your skin would be exposed to the harmful effects of the urine or stool.

Q What size should my skin barrier be?

A The opening in the skin barrier should be the same size as your stoma. This is not something about which you want to guess. Sizing guides are available free from Hollister Inc. as well as all other ostomy product manufacturers of skin barriers. If you are not sure that you have the right size opening or you want to try a skin barrier that is already pre-cut, you need to measure. Size does matter!

An additional note: Some skin barriers work best if they are cut 1/8th to 1/16th of an inch larger than the stoma with the gap filled-in with paste. Extended wear barriers—like the FlexTend by Hollister, Inc. or Durahesive by ConvaTec—may be sized actually to touch the stoma. These skin barriers are especially designed for individuals with greater amounts of liquid stool—like people with ileostomies, transverse colostomies or urostomies. People with urostomies should not use paste products to fill in gaps but should use convex barriers.

HOSPITALIZATION FOR OSTOMY PATIENTS

by Dr. Lindsay Bard; via Chicago (IL) The New Outlook; and Hartford (CT) The Hartford Ostomy Update

It is important for a person with an ostomy to know how he/she should be handled differently than someone without an ostomy when you need to be hospitalized. It's up to you. It is very important to communicate to medical personnel who take care of you, including every physician that treats you, that you have an ostomy, and what type of ostomy you

have. Here are some rules to help you cover the details:

Rule 1 – The Cardinal Rule!

If you feel something is being done or going to be done to you that might be harmful, refuse the procedure. Then explain why to the medical personnel, especially your physician. They will then decide with you if the procedure will actually be in your best interests.

Rule 2 – Supplies

Bring your own supplies to the hospital. Never assume the hospital will have the exact pouching system or irrigation system you use. Most hospitals have some supplies available. These are used for emergency situations.

Rule 3 – Laxatives & Irrigations

Follow the points below concerning laxatives or irrigation practices, according to which type of ostomy you have. Medical personnel often assume all stomas are colostomies. But, of course, practices vary among the various types of ostomies.

- A transverse colostomy cannot be managed by daily irrigations. The only colostomy that can be managed by irrigations is the descending or sigmoid colostomy. However, sigmoid or low colostomies do not have to be irrigated in order for them to function; many people with sigmoid colostomies prefer letting the stoma work as nature dictates. If you do not irrigate your colostomy, let the fact be known to your caregivers. If your physician orders your bowel cleared, irrigate your own colostomy; do not rely on others. There is a strong possibility that those caring for you will not know how to irrigate your colostomy.

- Bring your own irrigation set to the hospital.
- If you have an ileostomy or urinary diversion ostomy, never allow a stomal irrigation as a surgical or x-ray preparation.

Remember that laxatives or cathartics by mouth can be troublesome for people with colostomies. For people with ileostomies, they can be disastrous—

people with ileostomies should always refuse them. A person with an ileostomy will have diarrhea, may become dehydrated and go into electrolyte imbalance. The only prep needed is to stop eating and drinking by midnight the night before surgery. An IV should be started the night before surgery to prevent dehydration.

Rule 4 – X-rays

X-rays present special problems for people with ostomies, again, differently managed according to ostomy type:

- A person with a colostomy must never allow radiology technicians to introduce barium into your

stoma with a rectal tube. It is too large and rigid. Take your irrigation set with you to x-ray and explain to the technicians that a soft rubber or plastic catheter F#26 or 28 should be used to enter the stoma. Put a transparent pouch on before going to x-ray. Have the technician or yourself place the rubber or plastic catheter into your stoma through the clear plastic pouch. When enough barium is in your large bowel for the x-ray, the rubber or plastic catheter can be withdrawn and the open end of the pouch closed. The pouch will then collect the barium as it is expelled and can be emptied neatly after the procedure. Once the x-rays are completed, irrigate normally to clean the remaining barium from your colon. This will prevent having to take laxatives by mouth after the procedure.

- A person with an ileostomy may drink barium for an x-ray procedure, but never allow anyone to put barium into your stoma.

- A person with a urostomy can have normal GI x-rays without any problems. Never allow anyone to put barium in your stoma. At times, dye may be injected through a soft plastic catheter into a urostomy for retrograde ureter and renal studies, often called an ileo-loop study. The same study may be performed on a urostomy patient with a Kock pouch. The dye will be injected via a large syringe; this can be a very painful procedure if the dye is not injected very slowly. Even 50 mL will create a great deal of pressure in the ureters and kidneys, if injected rapidly. Remember to request that the injection be done slowly.

2012 UOAC Conference in Toronto

"Caring in a Changing World"

August 15 – 18, 2012

Delta Chelsea Hotel

Downtown Toronto

http://www.ostomycanada.ca/events/biennial_conference_of_uoac



http://www.ostomy.org/conferences_events.shtml



Check Us Out On The Web

www.ostomymcp.com

Other Websites Of Interest:
 United Ostomy Association of America: www.uoaa.org
 Your Ostomy Community Connection Center: www.c3life.com

Ostomy Chat Room Weekly Meetings

Yahoo Peoples with Ostomy2* - Mondays, 8:00 pm US Central time
<http://clubs.yahoo.com/clubs/peopleswithostomy2>

Community Zero (Ostomy) Support* - Wednesdays, 9:00 pm US Eastern time
<http://groups.yahoo.com/group/ostomatessupport/>

Yahoo UK Ostomy Support* - 1st & 3rd Sundays, 8:00 pm UK time / 3:00 pm US Eastern Time
<http://clubs.yahoo.com/clubs/ukostomysupport>

UOAA Chat Sundays 9pm ET / 6pm PT
<http://www.yodaa.org/chat.php>

Use this form to join our chapter! You do not have to be an ostomate to be a member and/or support the work of UOA. All information on this form will be kept confidential.

Name _____

Address _____

City _____ State _____ Zip _____

Phone# Home _____ Work# _____

Email Address _____

Type of intestinal or urinary diversion: Colostomy __, Ileostomy __, Urostomy __, Ileoanal Pull-thru __
 Continent Ileostomy __, Continent Urostomy __, None __, Other __

You may use my name in chapter Newsletter & Directory: Yes __ No __

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