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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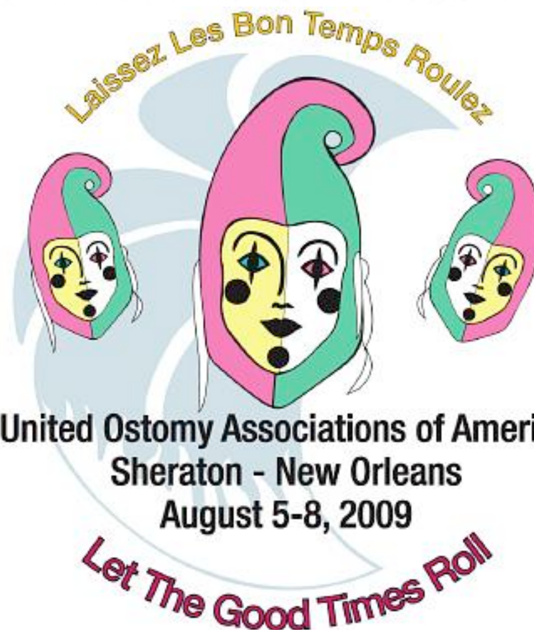
Our next meeting will be Sunday May 17th at 3pm.

4836 Victor Street



http://www.uoaa.org/conference_2009.shtml

For more information please visit the International Ostomy Association Website:

http://www.ostomyinternational.org

Is Bleeding Normal for a Stoma

By Gwen Turnbull, WOC nurse, Cleveland Clinic

It is normal to see a bit of blood on your washcloth as you cleanse around the stoma. The tissue from which the stoma is fashioned is very much like the lining inside your mouth. You know how easy it is to nick your gum with your toothbrush and cause it to bleed.

It is the same with your stoma. If you injure your stoma, it will bleed. If you take blood thinners or other medications; e.g., aspirin or aspirin containing medication, your stoma may bleed more than normal.

If you have another condition, such as portal hypertension or cirrhosis of the liver or another live condition, the stoma can bleed excessively. The bottom line is that if you cannot stop stomal bleeding with 15 minutes, or the bleeding is excessive, you should seek medical attention immediately.

Latent Risk of Cancer

By Patricia Murphy, WOC nurse, Chicago

There have been clinical reports on adenocarcinoma of the ileostomy after surgery. This is a brief overview of an interesting case of this subject that came to my attention after researching cases involving, "the latent risk of cancer after colectemy for ulcerative colitis and familial polyposis".

There was a person who had an ileostomy done for mucosal ulcerative colitis 29 years ago. She called and made an appointment to see me regarding some sore on her peristomal skin. When I saw the patient, the stoma looked almost like a double-barrel type instead of an ileostomy.

There was red, healthy looking mucosal tissue forming what looked like an extra stoma and smaller spots of this near the real stoma. I was surprised that she was able to use a skin barrier over all of this and that it stayed on for four days, even though this tissue was wet. I thought that perhaps leakage under the skin barrier had caused this condition; however, most of the skin looked fine.

I referred her to a surgeon who thought it might be excess granulation tissue. He treated the problem by cauterizing it with silver nitrate. The next week it looked worse and appeared to have a necrotic center. He biopsied it and it turned out to be adenocarcinoma of the ileum.

This is an extremely rare cancer. We could find only about two dozen cases that had been reported. They all had something in common: All of the people had their stomas for a long time—an average of 24 years. They either had a history of ulcerative colitis or familial polyposis. Most of these cases have been discovered over the last fifteen years. This may mean that there is a growing population of patients who have had their stomas for a long time. They may be at risk to develop cancer of the ileum.

It was suggested that it develops in this way: First, the ileal mucosa changes to colonic mucosa, then to colonic dysplasia, and then to adenocarcinoma. These changes resemble those that occur when a patient who has ulcerative colitis for a number of years and develops colon cancer. It is recommended that there be an annual evaluation of the stoma, looking for changes in the mucosal cells of the stoma —colonic metaplasia—inflammatory lesions consistent with ulcerative colitis and dysplasia.

The surgeon removed my patient's entire stoma and the involved skin. He made a new stoma on the other side of her abdomen. This wide excision of the tumor should result in a complete cure. The patient did very well and went home at a stay of only a few days in the hospital.

A very good outcome for these cases can be expected with early detection and resection.

The moral of this story is:
© Do not become complacent about your stoma, even if you have had it for a long time.
© Do watch for changes in the way it looks and functions, and for changes in the peristomal skin.
© Do continue to see your WOC nurse to have him/her examine your stoma every year of two.

Colostomy Blockage

By J. Hopkins, Asst. Prof. of Surgery, Lankenau Hospital, Alabama

Poor bowel habits probably begin in childhood with people being "bowel conscious". They erroneously think that a daily bowel movement is necessary for body and bowel functions. Four requirements for normal bowel passage are:

· Eating a balanced diet including some roughage
Attempting a rigid diet after a colostomy is futile and unnecessary. By trial and error, one can eliminate those foods, which may cause diarrhea and constipation.
· Exercising to maintain a good body tone
· The absence of emotional effects ... this is of course impossible most of the time.
· Adequate fluid intake

Colostomy blockage may be due to mechanical defects or failures. The most common cause of this type of stricture is

a narrowing of the opening of the stoma. Another mechanical cause is herniation around the stoma. Blockage may also be the result of strangulation or a sharp bend in the colon.

Your surgeon can correct the mechanical problems. Other causes of blockage may be improper diet, medication and the effect of your emotions on your digestive system. In addition, the position in which one irrigates (somewhat doubled over, for instance) may result in difficulty in elimination. Exercising of abdominal muscles would not be harmful to the colostomy and would promote good muscle tone in the area. If one irrigates, it is recommended that one use one of the newer designed cones instead of a catheter for increased safety.

Can Ostomates Donate Blood?

By Bob Baumel, North Central OK Ostomy Association

This is an updated version of an article I originally wrote for our August 2006 newsletter. I am including this missive because I have noticed that some of the newsletters from other ostomy groups have been printing the horror story referenced in my first paragraph below.

Ostomy newsletters sometimes publish warnings that people with ostomies, especially people with ileostomies, should not donate blood. An often-cited horror story concerns a person with an ileostomy who, after giving blood, developed a two-day case of dehydration that could not be relieved by drinking fluids, followed by a kidney stone that developed ten days later.

I am one person with an ileostomy who has always ignored those warnings. I donate blood regularly and have never suffered any ill effects. My object in this article is to examine this topic rationally, instead of relying on an anecdote that may be more of an urban myth than an actual event.

My conclusion is that most people with ostomies can probably donate blood without any problem although, if you have just had surgery, you may need to wait a while; i.e., you may not be eligible to give blood until a year after surgery. Of course, every person is different, and may have a variety of other health challenges in addition to the ostomy itself. It is not possible to make a blanket statement for all people with ostomies. Therefore, you should check with your doctor if you have any doubts about your ability to give blood.

The question in the title of this article involves two issues: Is giving blood safe for a person with an ostomy. In addition, will the blood from a person with an ostomy be accepted by the blood bank?

In researching these issues, I have spoken with the head nurse at my local Red Cross blood collection center, and checked the eligibility guidelines on the American Red Cross website at www.redcross.org. It should also be noted that rules for donating blood vary in different countries. My comments on this issue apply mainly to the United States, where the rules are set by the U.S. Food and Drug Administration.

When I wrote the first version of this article in Aug 2006, my lifetime total consisted of 79 whole blood donations. Now, as of Feb 2009, I have given whole blood 83 times and donated four double red blood cell (2RBC) donations. Most of my donations have been made after my permanent ileostomy surgery, which was done in 1992. Prior to that, I donated at least five times during the four years while I had a J-pouch—my J-pouch failed due to chronic pouchitis and was replaced by a permanent ileostomy. Before that, I even donated a few times while I had ulcerative colitis, although only during the first few years of the disease, while it was still controlled fairly well.

On the first question, whether giving blood is safe: Dehydration is certainly a valid issue, especially for people with ileostomies and others who have lost their colon, including people with J-pouches and Kock pouches. The colon normally plays an important role in absorbing water. People with urostomies also need to remain well hydrated to maintain urinary health. Therefore, they should drink extra fluids to stay well hydrated.

Dehydration was the villain in the horror story cited at the beginning of this article. Severe dehydration may result from various causes, such as an ileostomy blockage or acute gastro-enteritis accompanied by vomiting and diarrhea. By comparison, the dehydration resulting from a blood donation is relatively minor. The quantity of fluid removed—about half a liter, or about one pint—is far less than one would lose in an acute blockage or gastro-enteritis episode.

So, if one is careful to hydrate well before coming to the blood collection center, drink all the fluid that is offered at the center, continue to drink lots of fluid afterward, one probably will not have any problem with dehydration. Even so, if you think you are prone to kidney stones, or if you have any other concerns about the safety of giving blood, check with your doctor.

Meanwhile, if you are still concerned about dehydration, another option is available now, namely, the newer aphaeresis donations. Components of your blood are separated by specialized equipment while you donate, and some of these components are returned to your body in these procedures. I have donating with one of these methods, namely, double red blood cell (2RBC) aphaeresis, for over a year. In this technique, a double unit of red cells—twice as many as in a normal donation—are

taken, but everything else—including the plasma—is returned.

In addition, enough saline is pumped into your body to compensate for the volume of cells removed. In this way, there is no net loss of fluid and assuming you also drink something at the blood collection center, your fluid level when you leave the center will probably be higher than when you arrived! As a result, these 2RBC donations do not cause any dehydration. In spite of losing a double unit of red cells, one may not feel any of the tiredness afterwards that one might experience after a regular blood donation.

It should be noted that the specialized equipment required for these aphaeresis donations is not available at all local blood collection centers. To be eligible for the 2RBC procedure, one's hemoglobin—iron—level needs to be somewhat higher than for a normal blood donation.

Let us consider the second question, whether a person with an ostomy's blood will be accepted: Before donating, one needs to answer a list of questions—the donor history questionnaire—that seems to grow longer every time I donate. One will find that none of the questions require mentioning that the possession of an ostomy on your tummy. Having an ostomy does not disqualify you from giving blood. In addition, if any worker at a collection center tries to tell you otherwise, that person is misinformed.

The questions that need to be answered refer to specific medical and physical conditions that may make a person's blood unsafe to donate. Some conditions, which generally have nothing to do with having an ostomy, can disqualify a person permanently. Some may require you to wait for a time before giving blood. If you have just had surgery within the past year, especially if you received a blood transfusion during that surgery, you probably will not be eligible until a year after the surgery.

An important special case involves surgery for cancer. As we know, many ostomies are performed due to colon or bladder cancer. When I first wrote this article in 2006, most cancers required a waiting period of five years. In 2009, that waiting period has been reduced to one year. Current guidelines on the American Red Cross website say,

"Eligibility depends on the type of cancer and treatment history. If you had leukemia or lymphoma, including Hodgkin's disease and other cancers of the blood, you are not eligible to donate. Other types of cancer are acceptable if the cancer has been treated successfully and it has been more than 12 months since treatment was completed and there has been no cancer recurrence in this time. Lower risk in-situ cancers including squamous or basal cell cancers of the skin that have been completely removed do not require a 12 month waiting period."

If you currently have a chronic disease such as Crohn's disease or ulcerative colitis, you are probably eligible to give blood. Remember: I actually donated a few times while I had ulcerative colitis. On this topic, the Red Cross guidelines say,

"Most chronic illnesses are acceptable as long as you feel well, the condition is under good control, you have an adequate hemoglobin level, your temperature is normal when you come to donate, and you meet all other eligibility requirements."

In conclusion, most people with ostomies are probably eligible to give blood, although you may face a waiting period if you had surgery very recently. Of course, you may have other health conditions that make you ineligible. But it cannot hurt to try! At the collection center, medical professionals will review your health information, in a confidential setting, to determine if you are actually eligible.

Editor's note: We endeavor to provide you a differing opinion than the current advice offered by the physicians and WOC nurses that regularly contribute to our group. Be clear . . . it may be extremely dangerous and risky for someone with an ileostomy to donate

Enough Water?

By Tinkly Drinkly

It is advised that you drink enough water every day as a person with an ostomy to obtain the excellent results promised. What items should be included in the daily intake of water?

Beverages containing caffeine allow you to retain about 40% of the water in them. These include coffee, tea and soda. Milk, fruit and vegetable juices retain about 75% of the water. Alcoholic drinks even add some water. Beer retains about 25% of the water. All these do count toward your daily water intake. But beware; any drink adds other chemicals into your body. These chemicals may cause very harmful side effects that may lead to sickness; e.g., drinking too much beer or soda on a hot day. There is not enough water in these substances to wash away there toxic effect thereby leading to dehydration.

If you are thirsty, you are dehydrated. If your urine is cloudy or dark yellow, you need to drink more water. Urine that is clear or pail yellow in color indicates your body is getting the liquid it needs. Talk to your doctor to make sure you are not one of those rare people, like those with kidney disease, who should restrict their liquid intake. Otherwise, drink up.

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/

Shaz & Jason's Chat* - Saturdays, 8:00 pm UK time / 3:00pm US Eastern Time
http://www.ostomy.fsnet.co.uk/chat.html

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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