

# The Mailbag



Meetings are held at the Baptist Medical Center  
8th Floor - Meeting Room C - 3rd Sunday Quarterly @ 3PM

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## Next chapter meeting

### January 20, 2008

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Have you ever wondered what life is like as an Ostomate from others from around the world? If so you may like to read the International Ostomy Association quarterly newsletter called **IOA TODAY**. This a Quarterly Ostomy Related Newsletter" Bringing You Ostomy Related Information From Around the World . You may sign up for this **FREE NEWSLETTER** and view past issue via:

<http://www.ostomyinternational.org/Today.htm>.

Also found on their Website is a section called Publications:

<http://www.ostomyinternational.org/publication.html>.

This link takes you to a list of Ostomy related publications from across the globe. Another topic of interest found on their Website is Ostomy Related Help: <http://www.ostomyinternational.org/ostomy.html>. Within that page you will find:

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### Ostomy Related Facts

Ileostomy

Colostomy

Urostomy

Sex & the Single Ostomy

Sex and the Female Ostomate

Sex & the Male Ostomy

Ostomy Food Reference Chart

The above are PDF documents for you view.

International Ostomy Association

[www.ostomyinternational.org](http://www.ostomyinternational.org)

### Visit our chapter Website:

<http://www.ostomymcp.com/chapter/Jaxchapter1.htm>

## TEMPORARY OSTOMIES

by Nancy Brede, RN, ET, Via The Pouch, & The New Outlook, Chicago

Temporary ostomies are surgically created with the intent of reconnecting in the future. The anatomy of the gastroin-testinal system or urinary system is left intact.

Permanent ostomies are created with the intent that the ostomy surgery will not be reversed - usually the anatomy in the gastrointestinal or urinary system has been removed. Permanent ostomy surgery is usually performed when dis-ease or injury prevents maintaining the anatomical struc-tures needed for reversal.

A large number of temporary ostomies involving the colon are done on an emergency basis. The colon becomes obstructed or blocked, and stool cannot pass through. Because of the emergency nature of the surgery, the bowel cannot be cleaned and prepared ahead of time. Reversals - re-anastomosis or hooking the normal anatomy backup - then can be done later, when infection is not as likely and proper healing can take place. The most common situations and diseases requiring a temporary colostomy are:

Cancer of the colon with obstruction - or other abdominal cancer affecting the colon. Hirschsprung's disease, a disorder or malfunction in infants that prevents the passage of stool. Due to a lack of nerve cells in certain areas of the large intestine, stool is not moved through and an ostomy is necessary. Diverticulitis, a small out-pouching in the wall of the intestine, called diverticula, become infected. The diverticula may rupture or cause obstruction. Crohn's Disease may necessitate a temporary ostomy to allow the diseased bowel to heal.

Persons with temporary ostomies face many of the same problems permanent ostomates have. It's just as important for them to have support, reassurance, and teaching as it is for persons with permanent ostomies. They must learn proper skin care, stoma care, and pouching techniques. Often, stomas are not ideally situated on the abdomen, because of the urgency of the surgery. Thus, pouching and skin care can post difficult problems.

Following temporary surgery, measures need to be taken to improve the patient's health. He /she must be in the best condition physically. to undergo the major surgery for reconnection. There is also a time for the patient to deal psychologically with past surgery,

upcoming surgery, and possibly a newly-diagnosed disease. It may be a difficult time with all the changes and new challenges. Often, there are many fears and unanswered questions. Other people with ostomies and ostomy nurses may provide reassurance and the answers to these questions.

### Is Your Pouch Showing?

From Newsleak, DuPage County Ostomy Assn.

Are you worried about your pouching system showing under your clothes? On the other hand, is your stoma protruding so much that it shows through your clothes?

Most Americans today lead pretty busy lives at a relatively fast pace. Everyone seems to be concerned with his/her own individual happenings. Aren't you? By the way, what is the color of the bus driver's hair? Did the sales clerk in the store wear brown shoes or black ones today? What color was the bank teller's tie? Does your brother's wife have blue or brown eyes?

Give up? Forget about the uncalled for worries and enjoy each day. Remember that your attitude about your image will affect the attitude of your family and friends. Most of us are more conscience of our ostomy than anyone else around us is. Virtually no one in the world even knows what an ostomy is much less to look at one of us and see where it is, and if it is showing. Even your fellow friends with ostomies, when we get together often casually look at each other, checking to see if an ostomy shows. If we cannot see it, and we know exactly where to look and what to look for, how is anyone else every going to know? Be happy, you have been given a new life.



## Ileostomy Lavage

By: Dianne Garde

When someone with an ileostomy encounters a blockage, it is important to know how this should be treated. The term "Lavage" is used rather than irrigation. In the ostomy realm, the term irrigation generally refers to someone with a colostomy who gives themselves an enema on a daily basis to clear the colon of stool. The amount of water used is probably between one and one half liters. Trying to instill this amount of fluid into an obstructed ileostomy could be potentially dangerous as the pressure could cause a perforation.

The generally accepted method of treatment of ileostomy obstruction is to use saline (sodium chloride) to prevent dehydration and to utilize a bulb syringe with an open-ended whistle tip, 24Fr or 26Fr, catheter. The solution is sucked into the bulb syringe and gently instilled into the catheter and the contents sucked back into it again in an effort to break up a food bolus.

This should be done a number of times until the saline comes back clear. I would not recommend that a patient try this procedure unless he/she possesses the proper equipment and has been trained by a well- educated WOC nurse. This should not be attempted until an x-ray has been taken to determine that it is a food bolus and not a mechanical obstruction.

I would also recommend that if you feel you have an ileostomy blockage that you try to get to a major centre where there are qualified personnel familiar with the proper procedure to deal with the problem appropriately.

### International Ostomy Association

[www.ostomyinternational.org](http://www.ostomyinternational.org)

The IOA Today Newsletter Fourth Quarter 2007 is now available. If you would like to keep up with Ostomy related information from around the world, then please sign up for the FREE IOA Today Newsletter.  
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## Caring for Excoriated Skin

By Diane Duran, CWOCN

If after removing your skin barrier you find your skin to be red, denuded of skin, painful or sensitive, you have "excoriated skin." Excoriated skin is often caused by pulling off the skin barrier too aggressively. Follow the adage; "push the skin and pull the tape." Pulling at the barrier may rip the skin or tear off the top layer of skin. Excessive perspiration under the barrier may also lead to excoriated skin as well as movement of the barrier while wearing your pouching system.

If needed, remove the skin barrier with a non-alcohol adhesive remover made specifically by ostomy equipment manufacturers for this purpose. Simple hold down your skin with the adhesive remover pad and going from side to side, gently pull your skin barrier down and away from your skin. After gently washing the stoma and surrounding skin with warm water—using soap around the stoma is rarely beneficial and dry the skin thoroughly—usually by air-drying, never by rubbing.

Sprinkle the skin with an ostomy powder, like ConvaTec's Stomahesive Powder or Hollister's Adapt or Karaya Powder. Dust off the excess powder and place your new skin barrier on your abdomen. Some people rotate the placement of square barriers around the stoma to give some skin a chance to breath. However, research has shown that this technique is not very effective. Skin under a quality skin barrier repairs itself fast and better than if it is left out in the air. People who have had ostomies for many decades usually find that the skin that has been covered under a skin barrier is some of the healthiest on their entire body.

Always be gentle to your skin, and it will be good to you.



# Koolostomy Pouch Covers

[www.koolostomy.com](http://www.koolostomy.com)

**Visit our chapter Website:**

<http://www.ostomymcp.com/chapter/Jaxchapter1.htm>

## What to do about Pouch Odor

By Eileen T. Carter, CWOCN

- You should never be able to tell that someone has an ostomy by his/her smell
- Modern pouching systems are odor free
- No special precautions are necessary

It is only in rare cases that pouch odor needs special treatment. Disposable modern pouches are odor free, save for the brief odor everyone experiences during pouch emptying. Just be sure nothing has stained your clothes to leave a lingering odor. Cuffing the tail of the pouch at the start of each emptying should prevent soiling the outside surface.

Diet can also play a role in odor control. Certain foods may cause odor and certain others neutralize it. Keep track of your own body's response to foods and avoid those that cause unwanted odor especially if you may need to use a public restroom. As a general rule, the following foods may cause odor (the first three affect urine):

asparagus  
fish  
brussels sprouts  
broccoli  
some spices  
cauliflower  
onions  
beans  
cabbage  
garlic  
turnips  
eggs

Note: Most of us eat all of the above foods and never worry about odor. It is only when the pouch is opened that one would smell anything. Plus, these foods produce odor in people without ostomies that are not as easy to hide, yet they still eat these things.

On the other hand, parsley, orange juice and active-culture yogurt can help neutralize odors. A sudden increase in odor may be related to a bowel blockage. Contact your doctor or WOC if other symptoms occur, such as decreased output and cramps. A blockage must be dealt with quickly!

Another tactic to suppress odor is to treat the inside of the pouch. It is not recommended, but some of us use products like antibacterial mouthwash when applying a new pouch and after each emptying. Simply apply a dab of mouthwash to a tiny scrap of tissue and drop it into the bottom of the pouch. Do not put aspirin inside the pouch, a practice that was once in vogue, it could cause the stoma to bleed.

Odor-reducing ingestible pills are available for those still bothered by odor problems. Consult your WOC nurse, and if you decide to go this route be sure to follow the directions. Otherwise, you could be needlessly bringing on health problems.

Bear in mind, your sensitivity to your stoma's fragrance may be just that—your own sensitivity. Following a sensible lifestyle should allow you to be just as odor free as the next person. But if you sense difficulty, try these hints one at a time to see what works best for you.

## 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>

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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