

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

Next meeting
Sunday November 21, 2010.
3pm, 4836 Victor Street.
Speaker is Kimberly Starkey
(Customer Service Rep - Medical Care Products).
Subject: Stoma Complications



December Holiday Party will be held
3rd Sunday Dec 19th at 3pm at Patti's
Condo in Riverside. Call 733-8500 to
RSVP and for address and directions.

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.

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.

VISITING A PATIENT WITH A TEMPORARY OSTOMY - A PERSONAL REFLECTION

from Regina (SK) Newsletter; via S Brevard (FL) Ostomy Newsletter

As a certified visitor with the local ostomy chapter, I have had many occasions over the years to visit patients who have just undergone surgery that left them with a temporary ostomy. Usually a temporary ostomy is done on an emergency basis, as the result of a blockage or obstruction in the colon. This may be the result of diverticulitis, colon cancer, inflammatory bowel disease or Crohn's disease, and the result is a temporary ostomy to allow the bowel to heal. The intent is to reconnect the bowel at a later time, and many patients are told by the attending physician to expect to have an ostomy for anywhere from three to nine months.

My first thought as I headed off to visit a patient with a temporary ostomy was that this would be a piece of cake, and the visit would involve lots of questions about management of the ostomy. I also figured that the patient would be greatly relieved knowing they would not have to deal with an ostomy on a permanent basis. Boy, was I wrong!

This particular patient was angry beyond all belief, upset with what had happened to her and definitely not prepared to deal with anything as disfiguring as a colostomy. To be sure, she wasn't angry with me, but the medical profession as a whole suffered her wrath and it was quite evident that the nursing staff gave her a wide berth. She was NOT going to like this ostomy thing! Not having encountered this kind of reaction before, I wasn't exactly sure how to proceed, but I found myself listening to her frustrations and empathizing with her situation. This calmed her somewhat and she told me that I was the first person who had not treated lightly her fears about the ostomy. She felt people did not take her seriously because hers was only a temporary situation.

The visit actually went fairly well after that and although she was still angry with many things, I left feeling that she would manage her colostomy quite well in the short period of time she would have it. It impressed upon me that people with temporary ostomies struggle with the same fears and anxieties that all of us who have permanent ostomies do. In addition to this, because the surgery is done on an emergency basis, they have absolutely no time to prepare themselves for the eventual outcome, the ostomy.

Do I sound like an all-knowing and understanding saint?? Well, I don't feel like one on some of these visits. In general, I find most persons who have just had surgery resulting in a temporary ostomy to be very upset and unusually angry. They just hadn't expected this! I am sympathetic, as mentioned before, but the thought also crosses my mind, "Deal with it!"

Recently, I paid a visit to a woman who, after her emergency surgery, asked me how I could tolerate having a permanent ostomy! At that moment it seemed bizarre that I should be counseling her when I am the one who has to live with this thing on a full-time basis. She could look forward to a reversal. On the other hand, hard as it may sound, her comment actually helped me and I didn't have to hesitate a second for the answer. I know I cope with it because I wouldn't be here if it weren't for my surgery for colorectal cancer. I was 37 at the time and I suppose I had every reason to be angry but I wanted so desperately to live. The surgery and colostomy gave me a second chance at life, for which I am grateful.

I would like to be able to remind some of the people who have to live with temporary ostomies that their surgery likely saved their lives too, and that a few months is really not such a long time to live with an ostomy. But I also have to remember how very frightening this surgery is and how it is still considered such an awful thing to have an ostomy. Despite our attempts to educate the public about the normal lives we lead, who among us wouldn't choose not to have an ostomy? So I internalize my thoughts and sympathize and try to make the patient feel better about coping with their new situation. But a question still lingers: Why do some people marvel at their good fortune while others retreat into anger and disgust?

We humans are a complex lot.

Johns Hopkins Health Alerts:

By Johns Hopkins Health Alerts: Colon Cancer

Smoking and Colorectal Cancer: What the Studies Show . . . Researchers began investigating the relationship between smoking and colorectal cancer about two decades ago. The initial studies clearly showed that smoking increased a person's risk of developing precancerous colorectal polyps, but the data supporting a link between smoking and colorectal cancer were inconsistent.

More studies were conducted and now the results are in. Researchers at the European Institute of Oncology in Milan recently published findings from two meta-analyses (analyses of findings of a group of smaller studies) that showed smoking clearly increases a person's risk of developing both polyps and colorectal cancer. The first study, published recently in the journal *Gastroenterology*, analyzed data from 42 previous studies. The researchers found that not only were current smokers twice as likely as people who had never smoked to develop polyps, they were also at greater risk for developing the type of polyp most likely to turn into cancer.

The second study, published recently in *JAMA*, looked at data from 106 previous studies. This meta-analysis

found that smoking increased the risk of developing colorectal cancer by 18%. In addition, the risk of developing rectal cancer was higher than the risk of developing colon cancer: 25% and 12%, respectively. The researchers also found that risk increased in relation to the amount a person smoked. Specifically, regardless of whether a person smoked one pack a day for 50 years and another smoked two packs per day for 25 years, both had a 24% higher risk of developing colorectal cancer than someone who had never smoked.

Findings from a meta-analysis of 36 studies, published last year in the *International Journal of Cancer*, show that both current and former smokers have a higher risk of developing colorectal cancer than nonsmokers. As with the *JAMA* study, this report also showed that the risk of rectal cancer was higher than that of colon cancer.

These studies also found that people with colorectal cancer who smoke are more likely than those who do not to die of their disease. In the *JAMA* study, the odds of dying of colorectal cancer were 25% higher for smokers than nonsmokers. The *International Journal of Cancer* study found that current smokers were 40% more likely than nonsmokers to die of colorectal cancer were.

Safe Travel Tips

By Joseph Rundle, Aurora, IL Ostomy Support Group

With the terrorist alert on high and many concerned about safe travel at this difficult time, I thought I would offer you some useful tips.

Do not ride in an automobile. Autos cause 20% of all fatal accidents.

Do not stay home. That is where 17% of all accidents occur.

Do not walk across the street. Pedestrians are victims of over 14% of all accidents.

Do not travel by air, rail or water. People have 16% of all accidental deaths because of these activities.

However, only .0001% of all fatal accidents occur at your local ostomy support association's meetings. Moreover, virtually none of these happen during the business meetings. Obviously, the safest place to be is at your local ostomy association meeting. You better go to the next one, just to play it safe.

"I am only one, but still I am one. I cannot do everything, but still I can do something; and because I cannot do everything, I will not refuse to do something that I can do." —Helen Keller

ASG Advisory Board Request

By Jason Cesari, UOAA ASG Advisory Board Chair

I am Jason Cesari, the current UOAA (United Ostomy Associations of America), ASG (Affiliated Support Group, which is what our local ostomy association is referred to by UOAA) Advisory Board Chair. Our latest project is going to require a little assistance from all the local ostomy association members.

As many of us know, having an ostomy can be an overwhelming experience, especially at first. One of the questions people ponder is whether they will be able to continue to work. For example, I am a state trooper and wear an ostomy guard that protects my stoma from my 25-pound gun belt. It also helps protect my stoma against a direct hit when I become involved in a scuffle.

The stress of the operation and the unknown is tough enough without adding on the "what if's" and uncertainty about being able to work. Having the UOAA family support is something that has helped me so much in returning to a normal life. Being able to talk to other members and "pick their brains" has helped me get right back into the flow of life. We are lucky to have many ostomy association members with a wide variety of vocational backgrounds that bring with them their real-life experiences in pursuing their career goals while living with an ostomy. The Advisory Board is compiling a database of information, which all members of the local ostomy associations as well as people with new ostomies can access.

So what information are we looking for? Let me first say that this is a completely volunteer project. People can enter and leave at will. We hope to compile a list of members who want to share their experiences after ostomy surgery. We are asking of our local ostomy associations to inform their members of this project, and to ask those interested to provide us some background information. E-mail your interest to jason30plusnetwork@uoaa.org.

I know the help I received from members of the UOAA had a huge part in my getting back to work, and adjusting to life with my ostomy. I hope this project will help others.

Jason Cesari
 statie7104@yahoo.com
 UOAA Advisory Board Chair
 UOAA 30+ Network Committee Member
 UOAA Luzerne County Ostomy Support Group

You Have Adjusted to Your Ostomy When . . .

Forwarded By Fred Shulak via Stoma Life and Ostomy Outlook

- ® You stop spending all of your spare time in the bathroom waiting for your stoma to work so that you can empty the pouch right away.
- ® You can move about freely without holding onto your pouching system as though it might fall off at any minute.
- ® You make that first trip to the mailbox without taking along your emergency ostomy supplies.
- ® You stop grabbing your abdomen when the grocery clerk asks if you need help to the car with your bag.
- ® You go out for the evening and realize too late that you left your emergency kit at home.
- ® You think how lucky you are to be alive instead of how unlucky you are to have an ostomy.
- ® You attend the monthly support group meetings with an expectation of learning more about your ostomy while helping other people adjust to theirs rather than staying at home worrying about it all.



Check Us Out On The Web

www.ostonymcp.com

IOA Today 3rdQuarter 2010 Newsletter

IOA TODAY brings to you up to date **Ostomy related reports** from around the world.

<http://www.ostomyinternational.org/IOAToday/IOATodayThirdQuarter2010.pdf>

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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