

SASKATOON OSTOMY ASSOCIATION BULLETIN

March 2017

The Saskatoon Ostomy Chapter is a non-profit mutual support society for the benefit of people who have had, or are about to have, ostomy surgery.

The purpose of our chapter is to:

- Assist the medical profession in the rehabilitation of ostomates by providing, at the request of the physician, reassurance and emotional support.
- To promote up-to-date information concerning ostomy care and equipment to ostomates, and those involved in their care.
- To educate, develop and promote public awareness and understanding of ostomies.

VISITING SERVICES

At the request of the physician, Stoma Nurse or patient. The visitor is chosen according to the patient's age, sex and type of surgery. A visit may be arranged by calling the Stoma Clinic therapists at 306-655-2138. They will contact the Visiting Chairperson of the local Ostomy Association.

The Saskatoon Ostomy Association advises all ostomates to consult their physician or E.T. before using any product or method referred to in this bulletin or in any other publication.



#15 - 1610 Isabella Street East, Saskatoon, SK S7J 0C1
saskatoonostomy@gmail.com | www.saskatoonostomy.ca

UPCOMING CHAPTER MEETINGS:



When: Monday, March 6, 2017 - 7:00 p.m.
Location: Preston Park 1 - 114 Armistice Way
Program: Rap Session



When: Monday, April 3, 2017 - 7:00 p.m.
Location: Preston Park 1 - 114 Armistice Way
Program: TBA

April 22, 2017 Educational Seminar at the Saskatoon Inn.

Wheelchair accessible * Convenient washrooms
Refreshments and visiting period after each meeting
Spouses, family members and other visitors welcome

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President's Message

Hope everyone had a great Christmas and all the best in 2017.

We will resume our monthly gatherings on February 6, 2017 with a POT LUCK DINNER starting at 7:00 pm at Preston Park 1 (in the Chapel on the 2nd floor). Everyone is welcome to attend.

We are in the process of doing a Educational Semiar on April 22, 2017 at the Saskatoon Inn. Should be interesting with guest speakers, Ostomy suppliers representation as well as sponsorship. I'm hoping that this seminar will reach out to new Ostomates as well as our current members.

Yes I'm so happy to announce that we got West Jet Tickets for two, anywhere West Jet flies. We will raffle them off for \$5 a ticket and the draw will be made at the Seminar at 4:30 pm. All proceeds will aid young Ostomates to attend the Annual Youth Camp which is held every year at Bragg Creek in Alberta.

I'm also pleased to announce that our Library found a home at Carnegie Medical Supplies, 2301 Millar Ave. Thank you Wanda, James and Karen for all your hard work in setting it up.

Just had great time in Cuba, but unfortunately my tan is fading away. I would recommend this resort highly.

Gerard Dakiniewich



**SOA PRESENTS:
LET'S GET TO KNOW MORE ABOUT OSTOMTIES
EDUCATION SEMINAR
APRIL 22, 2017
SASKATOON INN
TIME: REGISTRATION 8:00 AM
SEMINAR 9:00 AM TO 5:00 PM
GUEST SPEAKERS AS WELL AS DISPLAY TABLES
LUNCH WILL BE PROVIDED
EVERYONE IS WELCOME TO ATTEND**

Items of Interest



Kathy Guina



JoElla Klassen



James Carnegie



Teri Schroeder

The Stoma Clinic is located at room 5706, A Wing, Royal University Hospital. If you wish to contact an ET, please phone 306- 655-2138. If you do not reach the secretary, please leave a message. Help Line: 306-655-4346, after hours 306-655-4409.

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The purpose of this chapter is to help meet the needs of its members. If you have any suggestions for guest speakers, questions for the Dear ET column or ideas to change/improve how we function, please let us know.

We have a Suggestion Box at meetings or send your ideas to: Saskatoon Ostomy Association, #15-1610 Isabella St., Saskatoon, SK. S7J 0C1

To continue your membership, please mail your check in the amount of \$30.00, along with the membership form from the newsletter to: Saskatoon Ostomy Association, #15-1610 Isabella St, Saskatoon, SK S7J 0C1

Please do not let the fee deter you from becoming a member - If you are having financial problems talk to the executive and we may be able to cover the cost. We are here for one another!

Visitation: if a person is wanting a visitor please email: saskatoonostomy@gmail.com or contact Kathy Guina 306-343-0334 or Prem Dhir 306-374-5841. Contacts can be in person, phone or by mail.

Did You Know?

Ostomates may choose where to purchase products. There are 2 ostomy supply stores in Saskatoon:

1. Carnegie Medical Supplies
2. Nordon Drugs

You may also choose to have your supplies brought in to your pharmacy of choice.

Ostomate Appreciation Day

Where: Carnegie Medical Supplies
2301 Millar Ave, Saskatoon

When: March 3rd, 2017 @ 9:30am - 2:00pm

Program: Coloplast Rep in store to show new products, coffee, donuts, laughter & wonderful conversations.



My Ostomy Journey By Dr. John Stephenson

Chapter 4: The conversion to a continent ileostomy

Sometime after we returned from California, I visited Norm Faulkner to renew my ostomy supplies and he told me about The Rudd Clinic in Toronto. Some of my ostomy colleagues had their ileostomy converted into a continent ileostomy called a Koch Pouch and they no longer needed to wear an appliance. This was awesome news to me, although I did not mind wearing an appliance, it was a real pain in the b*** so to speak, having to change it each week. My skin was often itchy and I could not scratch it. There was the ever present unpleasant odour and so on. My research was consuming all my time 365 days of the year, so I did nothing about a conversion, until 1982.

Dr. Charles Wright advised me to wait until the Head of Surgery at Toronto General, Dr. Zane Cohen published a seminal paper on his experiences with the conversion to a Koch Pouch. The paper appeared and Dr. Wright gave me a copy. Dr. Cohen had successfully performed over 100 conversions of ileostomies to Koch Pouches, and had only one failure. I think the failure was that a woman was not happy with the conversion. Dr. Cohen always insisted on seeing the patient first in order to discuss the procedure and to make sure that the patient was physically fit and that the conversion was the best treatment for the patient. In December 1982 I met with Dr. Cohen, and he agreed to do the conversion in January 1983. My wife would fly to Toronto at the end of January and escort me home. Well things did not go as smoothly as planned, and I ended up having to spend three weeks in Toronto General. The surgery was performed on a Wednesday and all went well. This time instead of a bag, I had an indwelling catheter into my stoma. The stoma did not protrude above the skin and was located slightly below my old stoma site which was now closed. The catheter was stitched to my skin around the stoma so that it would not fall out. Once again I was catheterized so I did not have to go to the toilet. There was also a drainage tube protruding from my left side and it was draining my stomach. Twice a day, a nurse would give me an injection of Demerol in my butt as a pain medication. Everything was progressing perfectly, my bowels were beginning to function normally as was

bowels were beginning to function normally as was evident from the collection of drainage in the bag attached to the indwelling catheter. On Friday, Dr. Cohen visited me before going home for the weekend and told me that on Monday he would remove the indwelling catheter and I would be shown how to evacuate my Koch Pouch. It looked like I would be ready to go home at the end of January as planned, just ten days after the surgery.

My nurse was late giving me my Demerol shot on Friday afternoon, because a patient had died in another room. Her shift was over but she rushed into my room and gave me the Demerol straight into my IV. My vision tunnelled down and there was a roaring in my ears. I said to the nurse, "wasn't that supposed to be injected into my butt!" She dropped the syringe on the floor and ran crying from my room. The next thing that happened was that a crash cart was rushed into my room and a team of Residents and nurses called out to me. "Don't go to sleep Dr. Stephenson, stay awake! Get up, get up!"

So they hauled me out of bed, and holding onto me by both arms, they walked me around the corridors, wheeling my IV poles, and all my drainage tubing and bags. They kept me on my feet for about an hour, before my metabolism was stabilized. Then put me back into bed with no more Demerol!

After all that excitement, I slept well but the following day I began to feel unwell. There was a bloated feeling in my abdomen, and I noticed that the drainage from my Koch Pouch had ceased. A Resident was called to see me, and she could find nothing amiss. But by Saturday night, I was getting very uncomfortable. I asked to see the Resident again and insisted that my drainage catheter was blocked, and I asked her to cut the stitches and remove the catheter. She was too scared to that and said Dr. Cohen would do it on Monday morning. Then I told the Resident that I could feel liquid gurgling in my throat, and I was scared that I would inhale that liquid into my lungs if I tried to sleep. She told me that the reason for the drainage tube into my stomach was to prevent that happening.

During the night, I used the control device to crank the head of my bed into an almost vertical position, so that I was no longer lying flat on my back. This worked and probably saved me from inhaling the

Chapter 4 continued

liquid in my throat. In the morning I refused breakfast and begged to see Dr. Cohen as soon as possible. He came to see me immediately when he got the message, and was very upset to see me in this predicament.

He removed the catheter and found that blood clots had completely blocked the drainage holes. When he reinserted the clean catheter, there was a monstrous outpouring of fecal fluids into the collection bag. The liquid in my throat subsided, and I was able to lie on my back again.

His concern was that my Koch Pouch had been stretched to near bursting, and his stitches may have leaked fecal material into my body cavity surrounding my intestines.

I developed a low grade fever, which he treated with a prescription of metronidazole, a drug commonly referred to as Flagyl. This persisted for several weeks, so I ended up staying in hospital for three weeks. We were all relieved that there was no need for a second surgery to mend a burst Koch Pouch, and to clean out the infection in my body cavity.

The Koch Pouch has worked wonderfully for 33 years now, but there is still a small problem. Evidently, about 1/3 of all patients that have a Koch Pouch suffer from a condition called pouchitis, an inflammation of the lining of the pouch. It responds well to a prescription of Flagyl, and goes away for several months. But it keeps coming back, just like a boomerang! Norm Faulkner told me that patients from the Rudd Clinic were advised to insert some normal saline in the evening, and let it bathe the lining of the pouch for several hours and evacuate the pouch before retiring for the night. This worked for a while, but was not a cure. When I retired in 2006, I saw Dr. Kanthan at the Royal University Hospital. He scoped my pouch and noted the inflamed tissue. He advised me to eat a cup of plain yoghurt every morning for breakfast. This I did and it worked perfectly for six years. Then suddenly it stopped working! The Mayo Clinic is continuing to work on this problem and have two recommendations. Dr. Jennifer Jones, a Gastroenterologist at the Royal University Hospital, told me about the work being done at the Mayo Clinic and suggested I try using a more powerful dosage of Lacto Bacilli called VSL 3. Unfortunately it had no effect on my pouchitis. The second treatment she recommended was a daily low dose of ciprofloxacin, called Cipro. It helped a bit but I ended up with a full tear of a tendon connecting my

right rotator cup, and a tear in my Achilles tendon. My physician at the community clinic, Dr. Douglas Bell told me that 1 in 100,000 people suffer this side effect of Cipro.

Since I knew that Flagyl always worked for me, I wondered if I could use a low maintenance dose of that instead of Cipro. When I googled that I found that the Mayo Clinic has been treating both ulcerative colitis and Crone's disease with a combination of these two drugs. After checking with Dr. Bell I began using a low maintenance dose of Flagyl. It has only been for three months now, and so far, so good. Web sites that are devoted to sharing experiences of people who suffer from inflammatory bowel disorders, including Crone's and ulcerative colitis, say that the only drawback is tingling and numbness in fingers and toes. So I will watch out for that complication.

Because my surgery is not the preferred procedure anymore, whenever I am booked into one of Saskatoon's hospitals for a scope of my Koch Pouch, it is always booked as a Colonoscopy. I have to explain to the nurses that it is not an examination of my colon, since I do not have one. Also, I tell them and the Doctor who is doing the examination, that they must NOT use a regular Colonoscope. It has to be a Pediatric Scope, since my opening has an artificial sphincter which will not allow liquid or gas to pass from the pouch to the outside world. No paramedic, or emergency staff will have any idea what sort of stoma I have, so I carry a medical alert that states "CONTINENT ILEOSTOMY FOLEY #14". A Foley catheter is what I use to empty my pouch, and the size is #14.

Let me finish this storey with something that will make you laugh. My daughter married into a very large pioneering family in Calgary. Many years ago we were invited to join the family for Christmas dinner. There were about 20 people seated at three tables. As often happens to me, my Koch Pouch made a loud gurgling noise. My daughter's father-in-law jumped up from the table and announced to all "it sounds like the coffee is ready!" This has now become a family joke, especially when my grandchildren laugh at the dinner table when Pop-Pop makes this funny noise.

This is not the end of my ostomy storey, I am looking forward to many more adventures in the years ahead.



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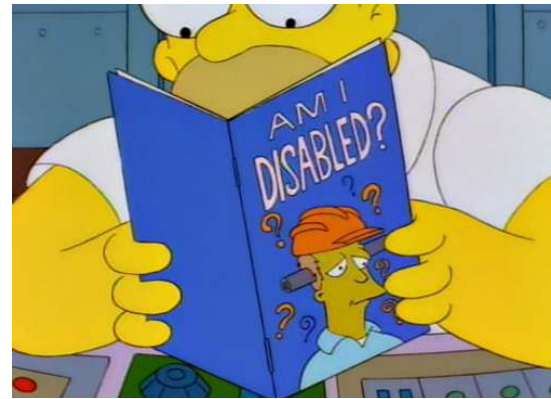
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Stoma Tips

1. Yes you can shower with your ostomy appliance on: following your shower pat dry with towel. For increased dryness use a hairdryer on cool setting.
2. Ostomy hernia belts are great for prevention of peristomal hernia's.
3. If your flange is chronically leaking underneath, 9 times out of 10 it is because your flange hole is too close to your stoma and mucous is the culprit. Try and cut flange hole 1/8" larger than your stoma.





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What is a Peristomal Hernia?

A peristomal hernia is a bulge under the peristomal skin indicating that one or more loops of bowel have passed through the dissected area of fascia and muscle, which was needed to externalize the stoma; and the bowel is now protruding into the subcutaneous tissue around the stoma (Thompson, 2008; WOCN, 2010, 2011).

oIt affects up to 50% of patients within one year following creation of the stoma (WOCN, 2011).

oIt may be associated with a prolapsed stoma (Husain & Cataldo, 2008).

oRecurrence is common (Husain & Cataldo, 2008):

- 50-100% after local fascial repair.
- 4-44% after local laparoscopic fascial repair with mesh.
- 68% after stoma relocation/translocation.

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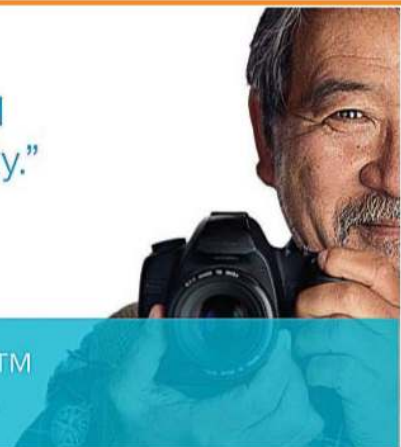
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Purple Urine Bag Syndrome: A Rare and Interesting Phenomenon

Discoloration of urine is not uncommonly encountered in clinical practice and may indicate a significant pathology. However, the majority of instances are benign and occur as the result of trauma to the urological system during procedures or ingestions of substances such as medication or food. Purple discoloration of a urinary catheter bag is rare and can be alarming to both patients and healthcare workers. This phenomenon is known as the purple urine bag syndrome. It is associated with urinary tract infections occurring in catheterized patients, generally elderly females with significant comorbidities and constipation. The urine is usually alkaline. Gram-negative bacteria that produce sulfatase and phosphatase are involved in the formation of pigment, indirubin and indigo. Tryptophan metabolism is involved in the pathogenesis. We present two cases of this rare and interesting phenomenon and discuss the underlying pathogenesis.

Discoloration of urine is not uncommonly encountered in clinical practice and may indicate a potentially significant underlying pathology. Red discoloration by blood may indicate a urological pathology and a dark brown discoloration indicates a hepatobiliary pathology. However, the majority of cases are benign and occur as a result of trauma to the urological system during procedures or ingestions of substances that cause discoloration. Purple discoloration of the urinary catheter bag is rare and can be alarming to both patients and healthcare workers. This phenomenon is known as the purple urine bag syndrome (PUBS). We present two cases of this rare and interesting phenomenon and discuss the underlying pathogenesis.

South Med J. 2007;100(10):1048-1050. © 2007 Lippincott Williams & Wilkins

PERISTOMAL HERNIA

A peristomal hernia is a bulge under the peristomal skin indicating that one or more loops of bowel have passed through the dissected area of fascia and muscle, which was needed to externalize the stoma; and the bowel is now protruding into the subcutaneous tissue around the stoma (Thompson, 2008; WOCN, 2010, 2011).

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oRecurrence is common (Husain & Cataldo, 2008):

- 50-100% after local fascial repair.
- 4-44% after local laparoscopic fascial repair with mesh.
- 68% after stoma relocation/translocation.

Identifying characteristics

- A bulge is noticeable around the stoma.
- oThe bulge can vary in size and it may be partial or circumferential.
- The bulge may reduce in size when the patient lies down and increase in size when the patient stands, sits, or exerts him/herself.
- The stoma may also change in size or shape.
- A hernia is often asymptomatic, or it can be symptomatic with pain, bulging, and poor fit of the pouch (Bafford & Irani, 2013).
- Subclinical hernia: If the patient's history suggests a hernia but the physical exam does not indicate a hernia is present, then further testing may be indicated. A cat scan with oral contrast or an upper GI x-ray such as a small bowel series or retrograde contrast study to visualize the loops of bowel may help determine if a hernia is present.

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Prevention of Peristomal Hernia

Avoid lifting over 5 pounds for 6 to 8 weeks after surgery.

oStop smoking (Arumugam et al., 2003).

oUse abdominal support belts and garments when doing heavy lifting or heavy work (WOCN, 2011). oSupport the abdominal area with a pillow or hands when coughing or sneezing during the post-operative period.

oAbstain from active abdominal exercises or lifting heavy objects for at least 3 months following surgery (WOCN, 2011).

oMaintain adequate postoperative nutrition (WOCN, 2011).

What is a J-Pouch and why can it change my life?

Ileoanal anastomosis surgery (commonly called J-pouch or IPAA) allows you to eliminate waste normally after removal of the upper and lowest parts of the large intestine (colon and rectum). J-pouch surgery avoids the need for a permanent opening in the abdomen (stoma) for passing bowel movements.

Ileoanal anastomosis is most often used to treat chronic ulcerative colitis and inherited conditions such as familial adenomatous polyposis that carry a high risk of colon and rectal cancer. Ileoanal anastomosis is also sometimes used to treat colon cancer and rectal cancer.

How is a J-pouch created?

In a surgical procedure called a total proctocolectomy and ileal pouch anal anastomosis (IPAA), the entire colon and rectum are removed. A reservoir is created from the distal small bowel (called the ileum), which is then joined to the anal canal. This pouch serves as a storage place for the stool that the patient is able to pass through the usual route, eliminating the need for a permanent external bag (ostomy).

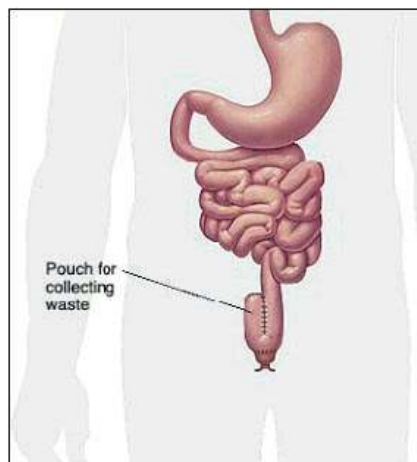
Who is a J-pouch for?

J-pouch procedures have become the preferred option for treating chronic ulcerative colitis (CUC) in which medical therapy fails to control symptoms. J-pouches also are used for familial adenomatous polyposis (FAP) and occasionally, colon and rectal cancer.

What are the benefits of a J-pouch?

In a survey of patients who had J-pouch procedures at Cleveland Clinic, one of the greatest benefits cited was having control over bowel movements and being free from the need to instantly find a restroom.

www.clevelandclinic.org



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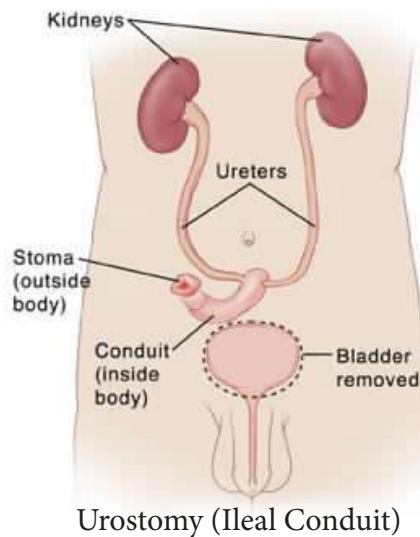
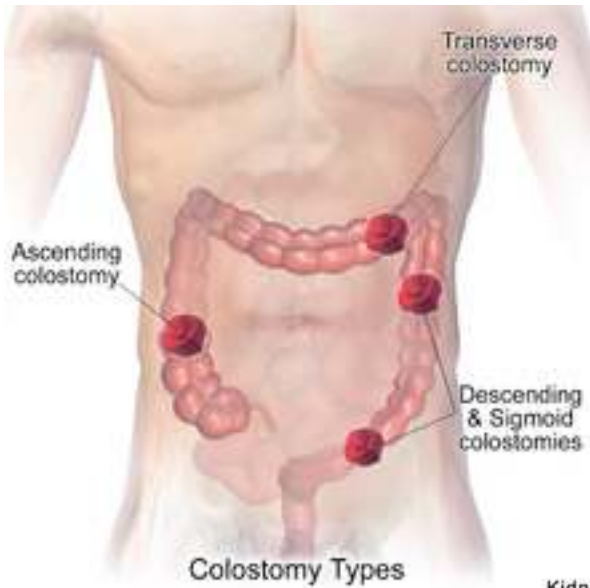
Please submit items for the bulletin by the following dates:

March 13, 2017

IMPORTANT NOTICE

Articles and information printed in this newsletter are not necessarily endorsed by the Saskatoon Ostomy Association or the Ostomy Canada Society and may not be applicable to everyone.

Please consult your own doctor or ET nurse for medical advice



APPLICATION FOR MEMBERSHIP

Yearly Membership Includes voting privileges, Issues of the Saskatoon Bulletin, and the UOAC publication "OSTOMY CANADA". The following information is kept strictly confidential.

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